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DECEMBER 1955

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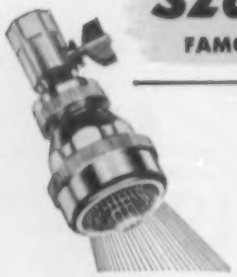



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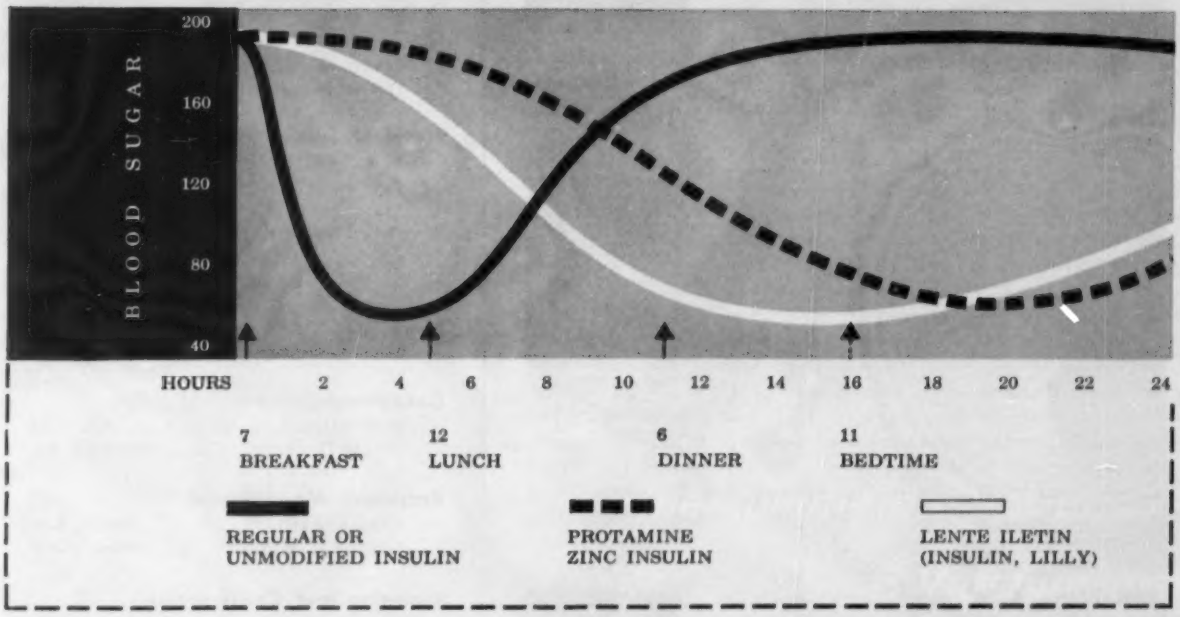
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Rae L. Smith is medical record librarian at Fayetteville City Hospital, Fayetteville, Ark. She was one of the record librarians to work under the "traveling librarian" program described in her article on page 87. As a result of the teaching and encouragement she received from the traveling librarian, Miss Smith became interested in a career, completed her training and became a registered medical record librarian. A graduate of the University of Arkansas, she was an elementary school teacher in the state for several years and has had her full-time position as medical record librarian at City Hospital now for eight years.


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Don E. Gilbert, who describes the essentials of a hospital department of inhalation therapy in the article on page 96, is chief inhalation therapist at the University of Michigan Hospital, Ann Arbor, Mich., and instructor in the subject at the University of Michigan Medical School. In addition, he serves as consultant in oxygen therapy at several other hospitals throughout the state. Formerly chief orderly at the University of Michigan Hospital, Mr. Gilbert was manager of medical gas distribution and oxygen rental for a commercial supplier in Ohio before returning to the hospital in 1950 to organize the oxygen therapy department along the lines described in his article. He is a member of the board of directors of the American Association of Inhalation Therapists.


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John French Allen, author of the article on the anti-noise campaign at St. Francis Hospital, San Francisco (*p.* 61), is science editor of the *San Francisco Examiner* and a close friend of San Francisco doctors and hospitals. Mr. Allen comes naturally by his interest in medical writing: His grandfather was a physician and his father is a newspaperman. Trained at Leland Stanford University, Mr. Allen began his newspaper career with the United Press, then spent eight years as head of the San Francisco bureau of *Time* magazine, for which he also covered Hollywood news during that period. Mr. Allen was in the navy during World War II as a gunnery officer with anti-aircraft units in the Pacific. Since his discharge from the navy he has been with the *San Francisco Examiner*. He also does some free-lance writing and teaches journalism at the University of California.


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Everett A. Johnson, author of the article on nursing time studies on page 52, is administrator of Methodist Hospital, Gary, Ind. A graduate of the University of Chicago's program in hospital administration, Mr. Johnson was administrator of Chicago Memorial Hospital, Chicago, for several years. When the board of that institution decided two years ago to merge with Wesley Memorial Hospital, Mr. Johnson moved to Gary. His experience during an epidemic of infant diarrhea at Gary last winter was described in an article appearing in The Modern Hospital for February 1955. Edward Nelson, co-author with Mr. Johnson of the article, is administrative assistant at Gary Methodist Hospital.

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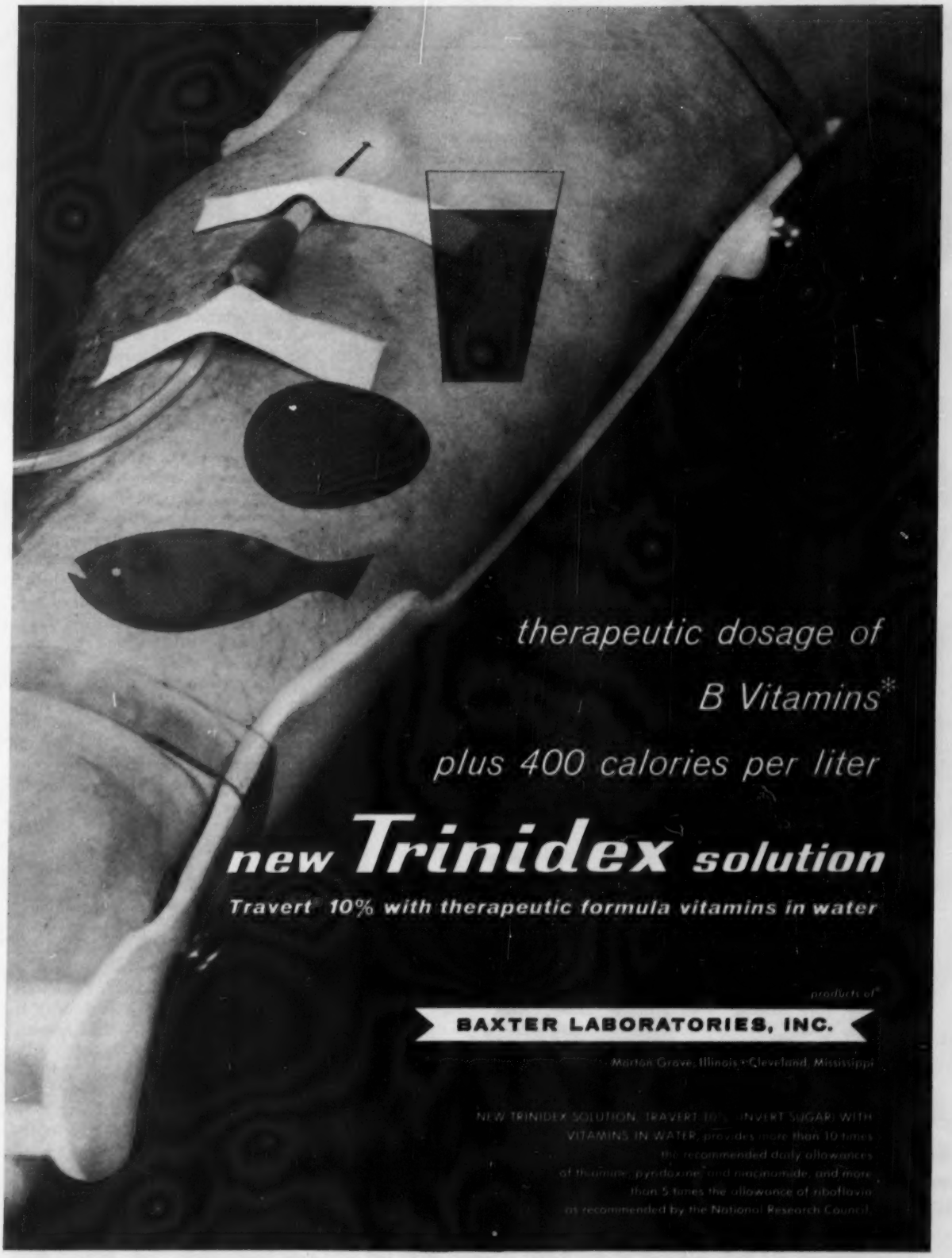
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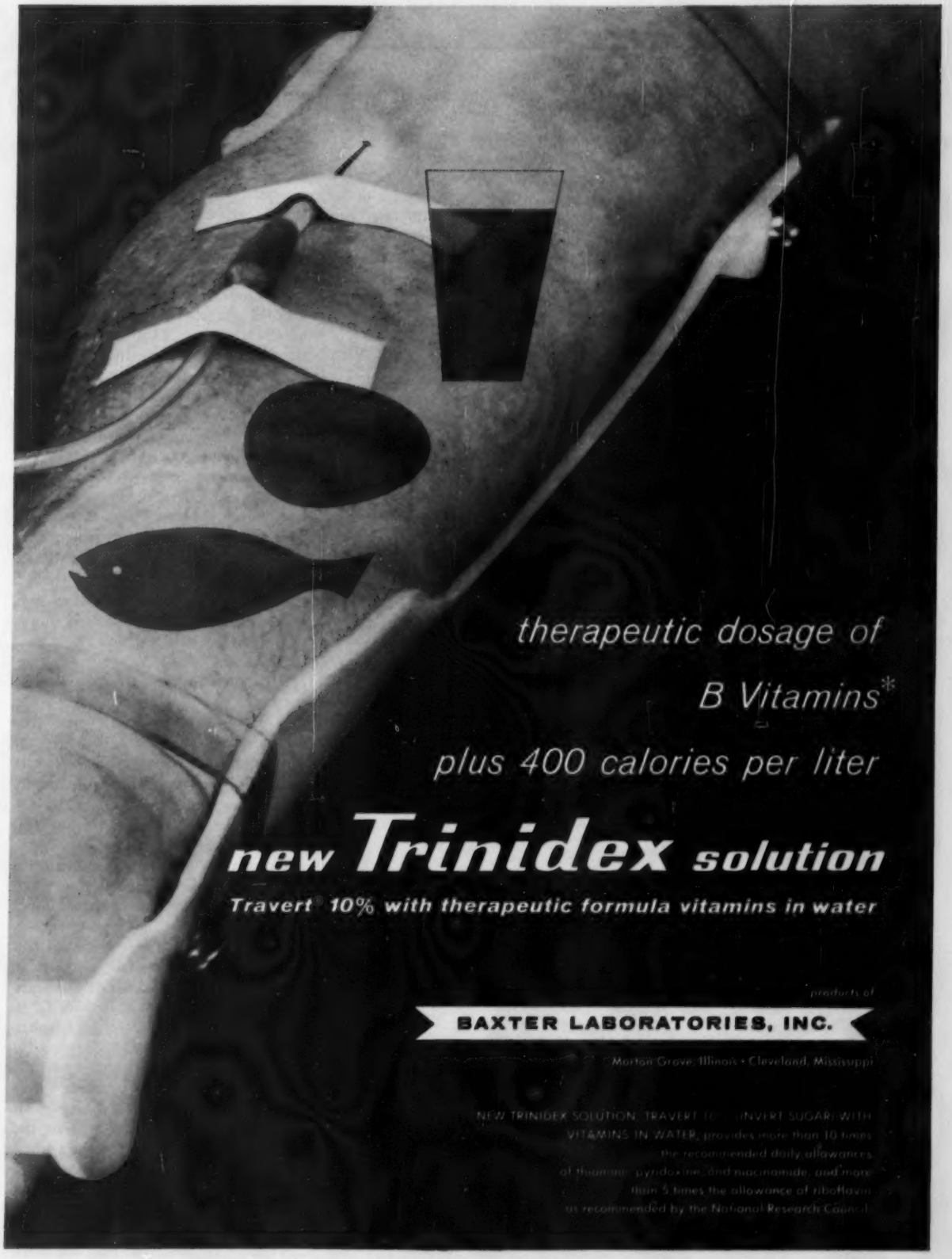
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READER OPINION

Economics of Food Service

Sirs:

Mr. May's noteworthy article "Economics of Hospital Food Service" is deserving of comment by members of the profession it most directly affects. It contains many statistics which have been needed and which will be of great value if they are correctly used as guides in the construction and management of hospital food service departments, with proper regard for the variability of specific hospital situations.

No two hospitals are alike and, therefore, no two food service departments can be identical. The danger in material of this kind is that it may be accepted too dogmatically, and in spots Mr. May himself seems to have fallen into this trap. For instance, he states definitely that tray service should be centralized, in spite of the fact that only two hospitals using decentralized service and two using centralized-bulk service were included in the study.

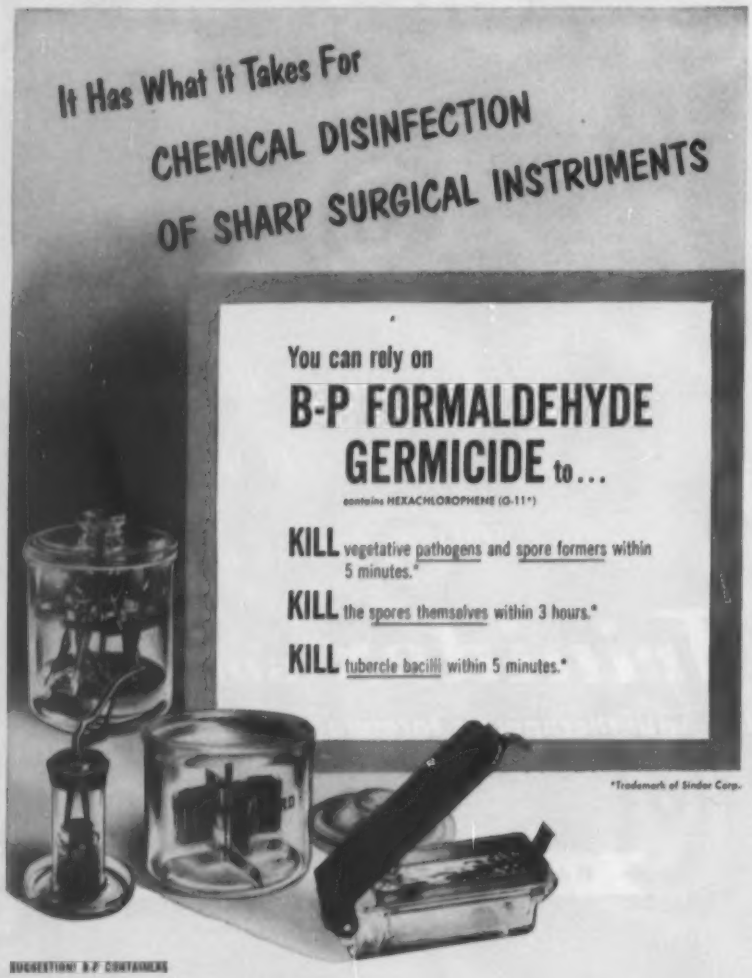
Monumental as the task has been of making intensive studies in 15 hospitals, the number is still too small for drawing such definite conclusions, especially with regard to type of tray service, where seven different methods were shown, with only two or three examples of each. It is true that the current trend does seem to be toward centralized tray service, and that it may be correct to say that this is usually the service to be preferred; but two cases are hardly sufficient evidence for changing the word "usually" to "always."

Then there is the matter of the number of dietitians required, which Mr. May says is a simple matter of the arithmetic involved in covering a schedule. One could wish it were that simple, but again, too many variables enter the picture which add to the requirement for basic schedule coverage. Here are a few of them:

1. How many modified diets are ordered and how complex are they?
2. How much teaching will the dietitian do?
3. Is the hospital engaged in research?
4. How much contact would the administration like the dietitian to have with the patients? With doctors?
5. Will dietitians work split shifts? (That day should have passed!)

Four dietitians are not enough in most 200 bed hospitals, and hasty interpretation of Mr. May's statement could be misleading.

Mr. May's conclusion that dining room space should be 14 to 15 square feet per seat has been established before, but a great deal of variation is to be expected in the number of seats required. Is this a pay cafeteria? If so, fewer people will use the hospital food service than if it appears to be free. A considerable number of employes will bring their lunch. Are they to be seated in the dining room or expected to eat elsewhere in the building? If the hospital is in a small community, many of its personnel will probably go home for lunch. How large a student group is to be accommodated? Are visitors to be served in the dining room? At least one small dining room will be needed for meetings of committees and other special groups. Will one such room suffice?



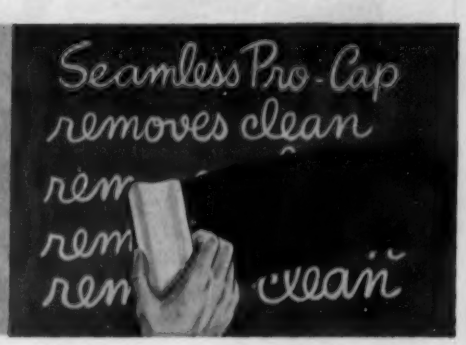
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All of these matters of policy must be settled by the hospital administration before the dining room space allotment is made. Many more instances could be cited, where the conclusions seem too inflexible.

On the other hand, Mr. May's sympathetic approach to the dietitian's need for proper offices, adequate help, and a functionally efficient physical plant is greatly appreciated. The research which has been done is most valuable and dietitians will be happy to have this needed information. They will agree with most, if not quite all, of the conclusions. The only fear is that some dietitians, some administrators, and some trustees may substitute "always" for "usually" in the use of the data, and may accept these figures and these conclusions too literally without allowing for the variations inherent in every hospital.

Mary W. Northrop
Chief Dietitian
King County Hospital
Seattle

ROVING REPORTER

"Water-Water-Everywhere—"

If you see a man with a forked hazel stick pacing the hospital grounds anywhere in Connecticut, Massachusetts or Pennsylvania, you will guess his purpose. He is fixin' to drill a well.

Hiram Sibley of Yale-New Haven Medical Center is one voice crying for an emergency water supply on hospital property in New England and elsewhere. "Water and power are the two basic needs that a hospital must prepare for in the event of emergency," Mr. Sibley says. "All too few hospitals have emergency lighting and power systems, and fewer still have an emergency water supply."

During the recent floods in Connecticut, Litchfield County Hospital of Winchester, which is in Winsted, first collected rain water for washing dishes and flushing toilets. The neighbors on the hill behind the hospital, who did not have town water, brought milk cans full of water for drinking purposes. But the rains stopped, and there was no more water for routine non-drinking purposes.

Then it was that someone remembered that, when the hospital was built, back in 1900, an artesian well had been dug and had never been used. Water in this well stood within 30 feet of the top, so Supt. William H. Sisson promptly got a deep well pump and, two days after the floods began, there was hot and cold running water all through the hospital again. However, the well did not recover fast enough to keep the hospital supplied, and that source had to be supplemented by a tank truck, which carried 1000 gallons at a time. The truck hauled six or eight loads every 24 hours until the city water supply was again available.

Another piece of luck at this Connecticut hospital, and many others in New England and the North Atlantic states as well, was their preparedness for the needed typhoid injections following the flood contaminated waters. During the summer the state had been giving polio shots so when the health officer ordered typhoid shots the hospital had all the polio syringes and needles sterilized and ready for use.




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Another hospital that had a secure water supply during the floods was Easton Hospital at Easton, Pa. It is located in an area where many homes and farms have artesian wells. Civil Defense supplied the hospital with army trucks to transport water from these wells.

To return to typhoid inoculations following the floods, St. Mary's Hospital, Waterbury, Conn., was surprised into inoculating 8000 persons. Official centers for mass inoculations were being set up, but the townspeople, especially the older people near the hospital, remembered that during the Depression of the 'Thirties, long lines of hungry persons came to St. Mary's and were given food. Their first thought was to get to the hospital that had served them in other times of need.

They came in such numbers that it became impossible to explain to them that the hospital had not been asked to take on this extra burden. The hospital was reluctant to turn away frightened people asking for help so it inoculated 4000 over the first week end in the outpatient department. By the following Tuesday the crowds were still so large that the inoculation unit was moved to the larger nurses' home, and on that one day 3527 persons were inoculated there.

The hospital's business department took on the vast amount of clerical work necessary for the inoculations. Volunteers came in and helped make out inoculation histories and certificates; they answered the telephone and typed lists; they comforted people who kept coming back to the hospital hour after hour, day after day, for news of their lost relatives. At times of peak emergency, there was not even time for the hospital to record the names of these volunteers. They left as quickly and quietly as they came after the emergency was over.

Easton Hospital in Easton, Pa., was also a polio center, and for this reason the community had on hand 1800 5 cc. syringes and 3000 needles for use in giving injections of Salk vaccine. So this hospital, too, was prepared to give typhoid inoculations to persons in areas where the floods had endangered the water supply. Let's follow Arthur H. Brittingham's account of these inoculations. Mr. Brittingham is administrator of Easton Hospital:

"The county health director was on vacation, so my office started to receive telephone calls, radio messages, and appeals by messenger from outlying areas inquiring about typhoid vaccine and help in giving it. The state department of health through Civilian Defense dispatched state troopers to the manufacturing source in Philadelphia and promptly had 10,000 cc. of typhoid vaccine in my hands, with authority to issue it at my discretion. If more was needed, they would fly it in.

"About 4 a.m. Sunday, August 21, I advised Civilian Defense headquarters to notify the various areas that the vaccine was available, and that our medical field team was ready to assist if requested. Records were set up in my office and the procedure was quite simple. On written or oral request of any single physician designated by Civilian Defense in a stricken area, the requested amount of vaccine was charted in the office record, showing the date, physician's name, area and amount authorized. A requisition signed by me was given the messenger who presented the request to our pharmacist, and the vaccine was issued.

"Easton Hospital was the single source of supply; every area could be observed, and at no time were any questionable demands made nor was there doubt as to our ability to meet these demands. Each area furnished us an estimated number of people needing to receive the vaccine; therefore, we knew the need of that area for the second and third shots. When requested by some communities, we also supplied sterile packs of needles and syringes, together with containers of alcohol sponges.

"We extended to all physicians in the area 'on the spot' courtesy privileges at Easton Hospital for the admission and care of their patients. At 2 p.m. that day we received a call from the physician serving Riegelsville, a community with a normal population of about a thousand located in near-by Bucks County. He had ordered mass inoculations and needed vaccine and help. I was advised we could use the local library there and requested him to notify the community that a team would arrive that afternoon at 4:30 p.m. To expedite our trip, we requested army convoy since all the roads were closed. A team of nine nurses and two interns was assembled. The C.D.R. crew packed the ambulance with necessary serum, sterile syringes, needles, penicillin, cortisone and other medical supplies 'just in case.'

"Registration tables were set up in

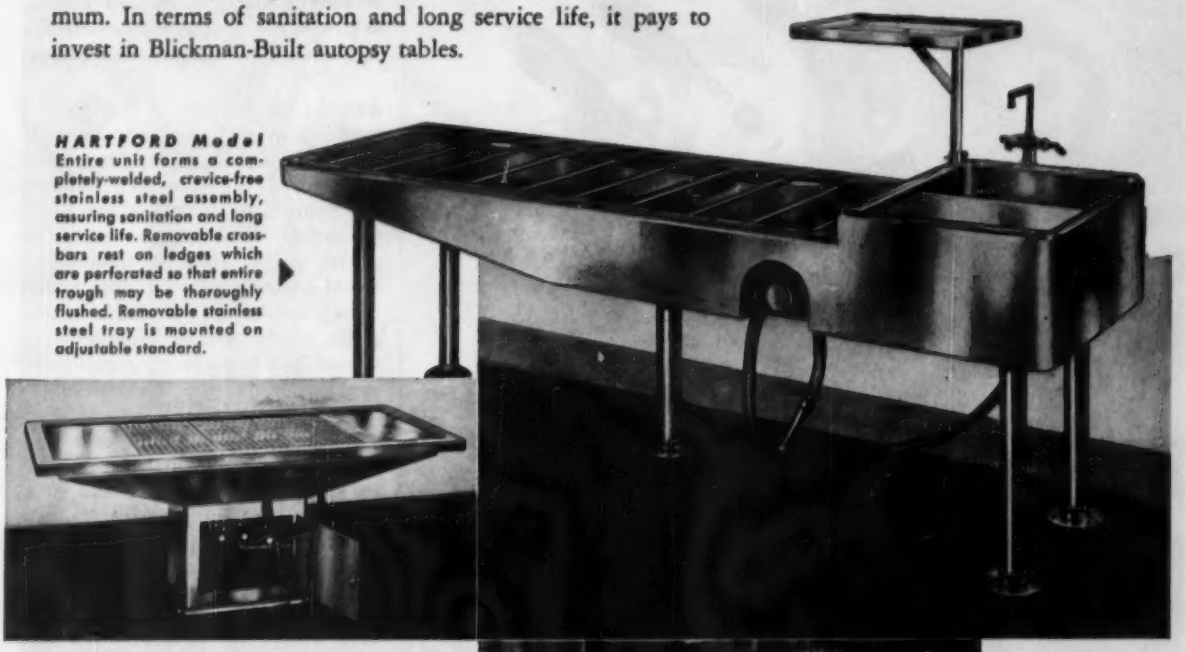
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You are welcome to our exhibit at the Association of Operating Room Nurses Convention, Hotel Statler, Boston, Mass., Booth Nos. 28 and 29, Jan. 30-Feb. 1.

an adjacent room at the Riegelsville Public Library, starting about one and one-half hours before we arrived. Each registrant was given a red tag, which we collected after the shot was given and used for tabulation. We set up a draped table 12 feet long and 3 feet wide. Syringes were loaded and spread out for the first 500 injections. Six nurses lined up in front of the table and three 'cleared the working area' and fed syringes to those giving the shots. People were lined up outside the working area and passed systematically to each nurse and out a door on the far side of the room. I would have the team work steadily for 30 minutes, shut down for a coffee break for 15 minutes, then continue this routine. At the end of two hours we would stop; supper would be served, and in about 40 minutes we would resume injections. Infants and those complaining of illness or injuries would first be examined and treated by a physician in a station we established near the working center.



Medical field unit team at Easton Hospital, Easton, Pa., including personnel of central supply room and clerical help who did most of the behind-the-scenes work during the flood period.

"The team averaged about 450 injections an hour and, in all, gave more than 5000 injections on six field trips to Riegelsville, Raubsville and Portland, three communities that suffered severe loss of life, homes and property. In addition, our team treated more than 100 persons for various types of illnesses and injuries. On second and third visits only the nurses, the chief engineer, and the laundry manager (both of whom wanted to assist), and I made the trips. On each trip we were entirely self-sufficient. These people worked hard, at night after their regular tour of duty, without compensation, and on many occasions we 'lived out of the lunch box.'

"During the disaster the Red Cross established reception centers in Easton and received and cared for those without homes. Each morning and evening we would send our ambulance with an intern to examine and treat those needing medical care.

"By Saturday, September 10, we were back to normal operation and without restrictions. We made our last field trip on Wednesday afternoon at which time the third and final injections were given 1400 persons."



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With new construction so costly, many prudent hospital administrators are discovering how MODERNFOLD doors give them more space —economically.

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Tell us the type and color of conductive floors you have and we'll see that you receive samples of the correct Wax for your use. There's no obligation. Write your request to Huntington Laboratories, Inc., Huntington, Indiana, today!

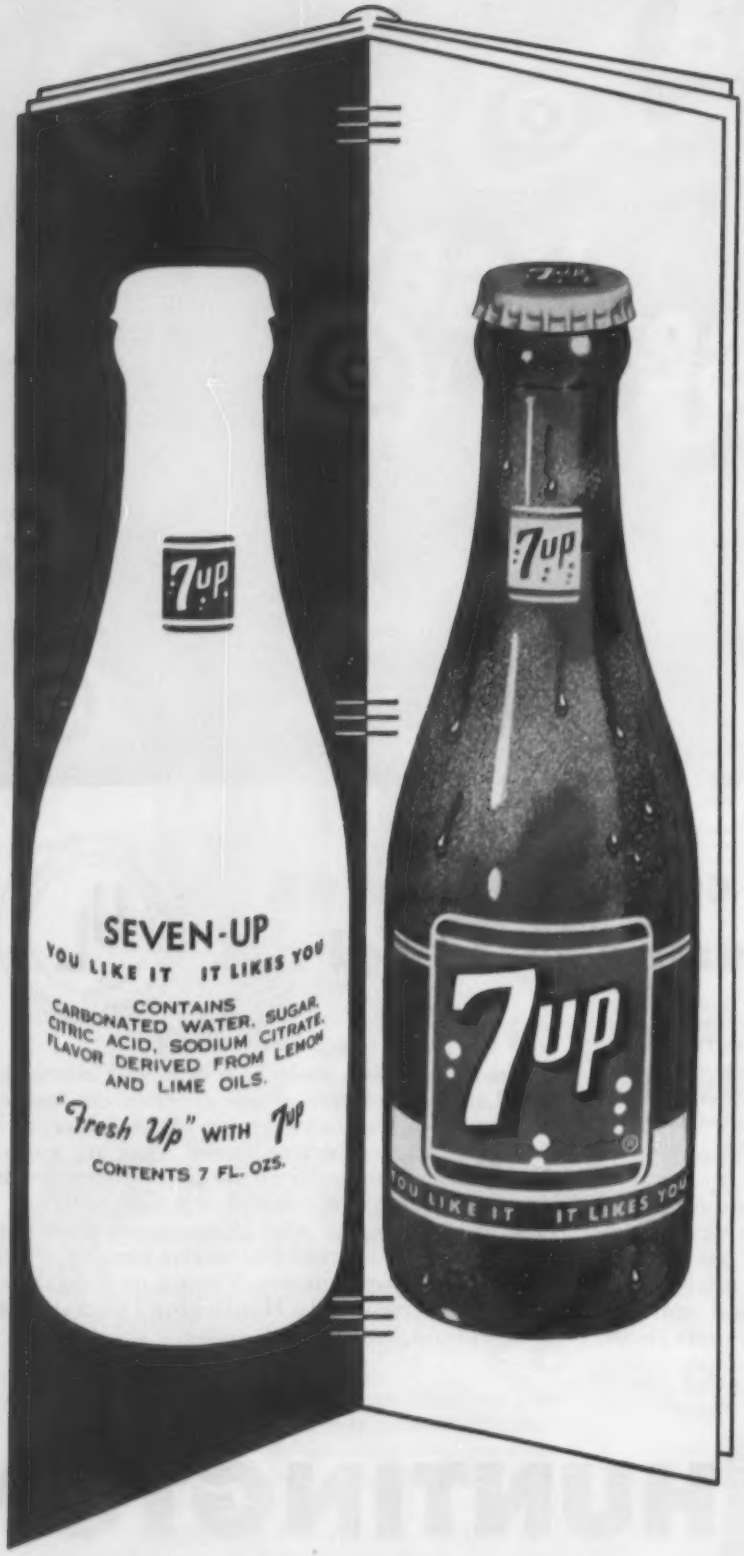


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If you hanker for a cool, clean taste . . .
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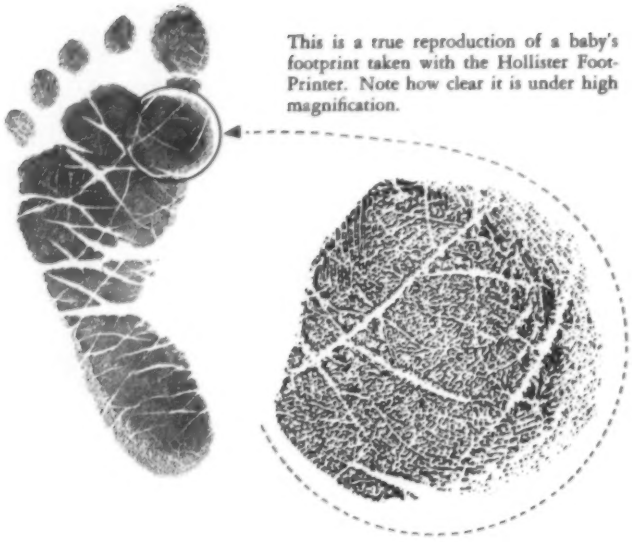
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"My word... such perfect Footprints!"



To see how these footprints got so perfect . . . turn page

NOW... perfect footprints for your protection!



This is a true reproduction of a baby's footprint taken with the Hollister Foot-Printer. Note how clear it is under high magnification.

THE primary purpose of taking new-born footprints is to establish legal, lifetime identification, which protects the hospital by providing evidence of each new-born's identity. As the FBI has stated "The purpose of taking footprints is to provide a permanent record of individuality so that in the event a question should arise later as to the identity of the child and its mother, conclusive proof of its identity can be offered. The footprints of the infant, therefore, should be taken at birth."* Yet, even today, hospitals are taking thousands of baby footprints that have little, if any, identification value. This is because the old-fashioned methods that were originally designed to take prints of thick, coarse adult skin are being used to take prints of soft, delicate baby skin. This, of course, results in footprints that are heavy, filled-in blobs of ink, unsuitable for identification. And that is why the revolutionary Hollister FootPrinter was developed.

Why is the new Hollister FootPrinter revolutionary?

First— it embodies an important, unique principle of taking prints — it uses a special dry plate instead of a wet and soppy ink pad or messy glass and ink roller. Instead of a thick coating of ink this new dry plate puts a light, very even film of color on the infant's microscopically fine skin. Then, when the print is taken, each tiny whorl and line can be clearly and perfectly reproduced.

Second–research proved that in order to get the perfect print made possible by the new dry plate method, the print had to be placed on paper that is smoother than the baby's fine skin. Ordinary paper isn't smooth enough to print an exact reproduction of the baby's fine skin. For this reason, prints taken with the Hollister FootPrinter are placed on glossy Kromekote paper, which furnishes lifetime identification for permanent hospital records. And further, Hollister-taken prints on Kromekote paper can be easily microfilmed because each little whorl and line is so clearly distinct.

Beyond this, with the Hollister FootPrinter nurses can take prints in seconds — instead of minutes. They do it by merely pressing the newborn's foot lightly against the sensitive dry plate — then taking the print. And that's all! It does away with the mess and bother of smeary tubes and messy pads of ink. And the baby's foot stays practically clean, as do the busy nurse's hands. There's no difficult wash-up of baby's foot. The dry plate fits snugly into a sturdy plastic case and will take 150 prints. Then, when the plate's color is used up, it can be discarded and replaced with a fresh plate.

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*FBI Law Enforcement Bulletin, January, 1945

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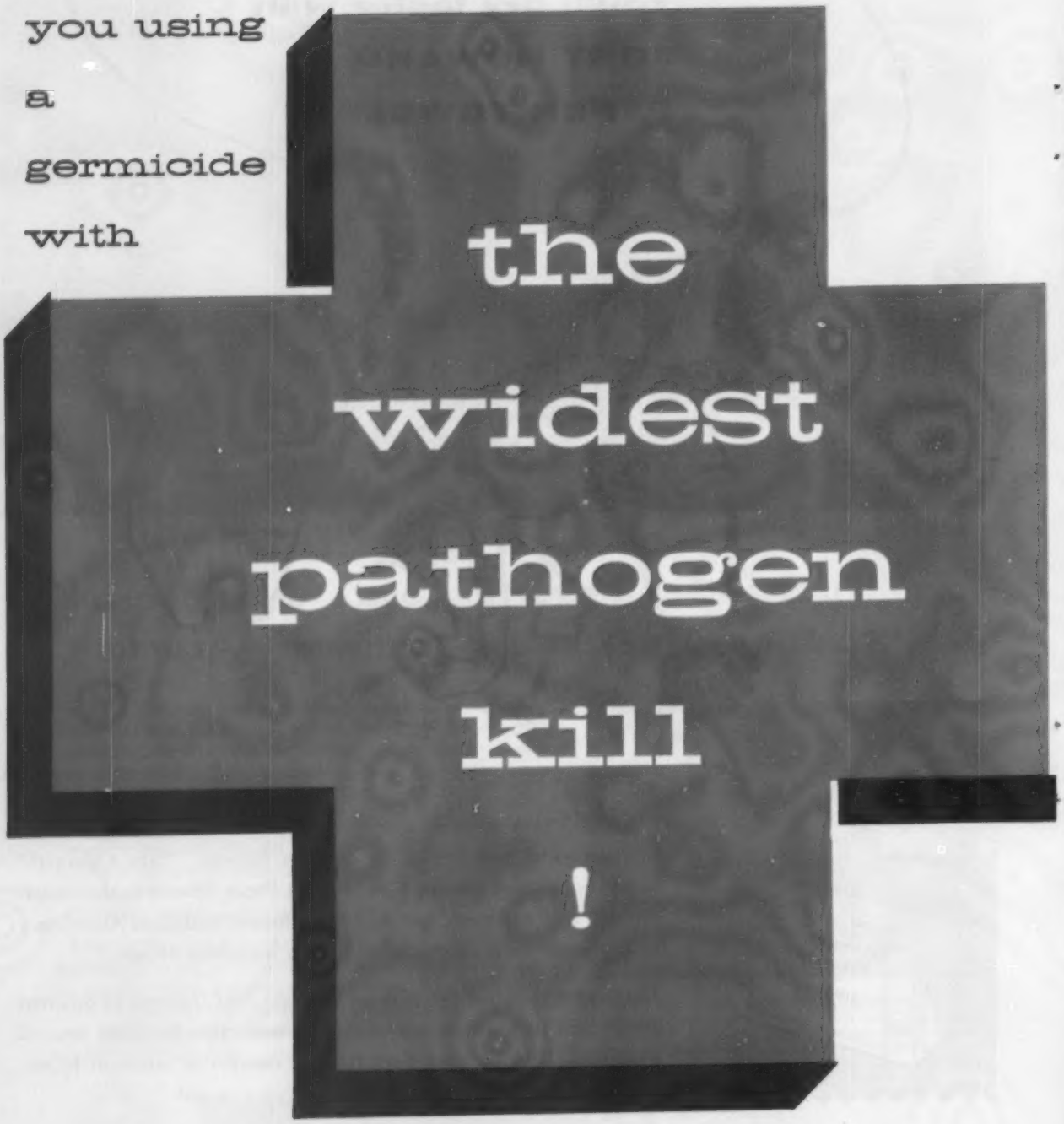


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Provides amazing cleaning action as it disinfects. Does both in a single operation. A time and labor saver.

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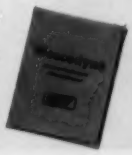
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Conforms

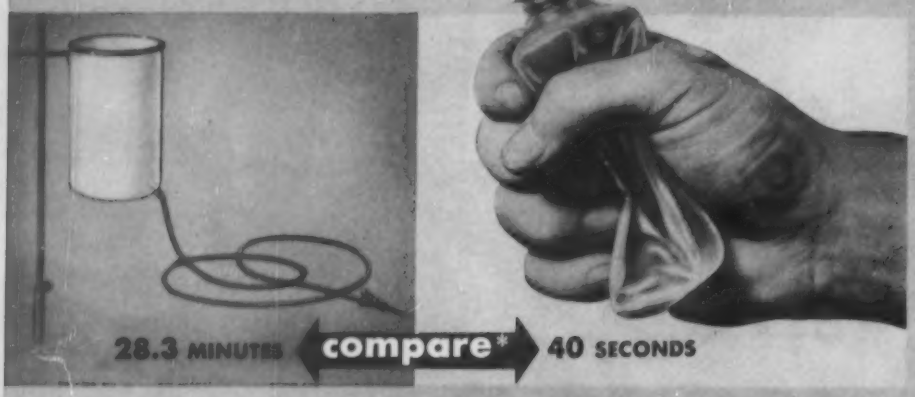
Molds smoothly and naturally to any body contour.

Johnson & Johnson

When you save TIME
you save MONEY

FLEET ENEMA *Disposable Unit*

NOW AT A NEW, LOWER PRICE



It takes only *40 seconds* to prepare and administer a routine enema with the Fleet Enema Disposable Unit. Using cumbersome, old-fashioned equipment, preparation plus instillation plus "clean-up" and sterilization consumes *28.3 minutes.*

Only FLEET ENEMA Disposable Unit *offers these conveniences* . . . one hand administration . . . sanitary, individually sealed rectal tube . . . built-in rubber diaphragm to control flow, prevent leakage.

Each individual 4½ fl. oz. unit contains, per 100 cc., 16 gm. sodium biphosphate, and 6 gm. sodium phosphate, an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.

Founded in 1869



**From a soon-to-be-published time-cost study.*

† "Phospho-Soda", "Fleet" and "Fleet Enema" are registered trademarks of C. B. Fleet Co., Inc.

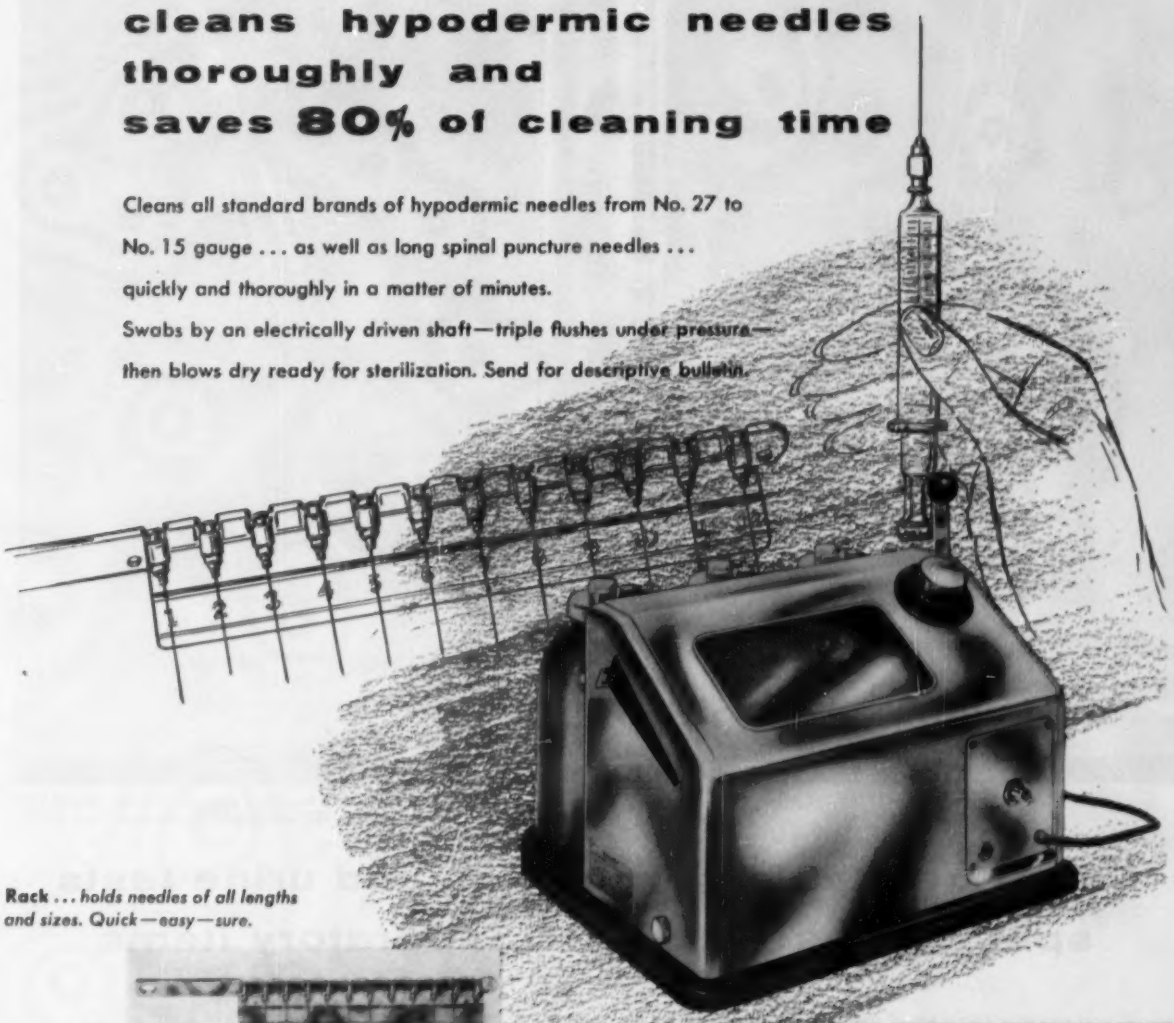
C. B. FLEET CO., INC. • LYNCHBURG, VIRGINIA

Manufacturers of "Phospho-Soda", a laxative of choice for over half a century.

AMERICAN Needle Cleaner---

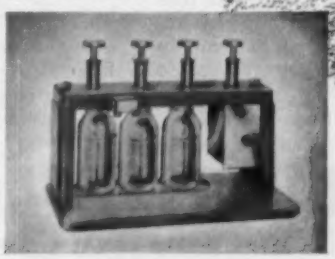
cleans hypodermic needles thoroughly and saves 80% of cleaning time

Cleans all standard brands of hypodermic needles from No. 27 to No. 15 gauge ... as well as long spinal puncture needles ... quickly and thoroughly in a matter of minutes.
Swabs by an electrically driven shaft—triple flushes under pressure—then blows dry ready for sterilization. Send for descriptive bulletin.



Rack ... *holds needles of all lengths and sizes. Quick—easy—sure.*

Model "S" Hypodermic Needle Cleaner *for the small hospital, clinic or doctor's office ... provides equal cleaning efficiently in a lower capacity hand operated model.*



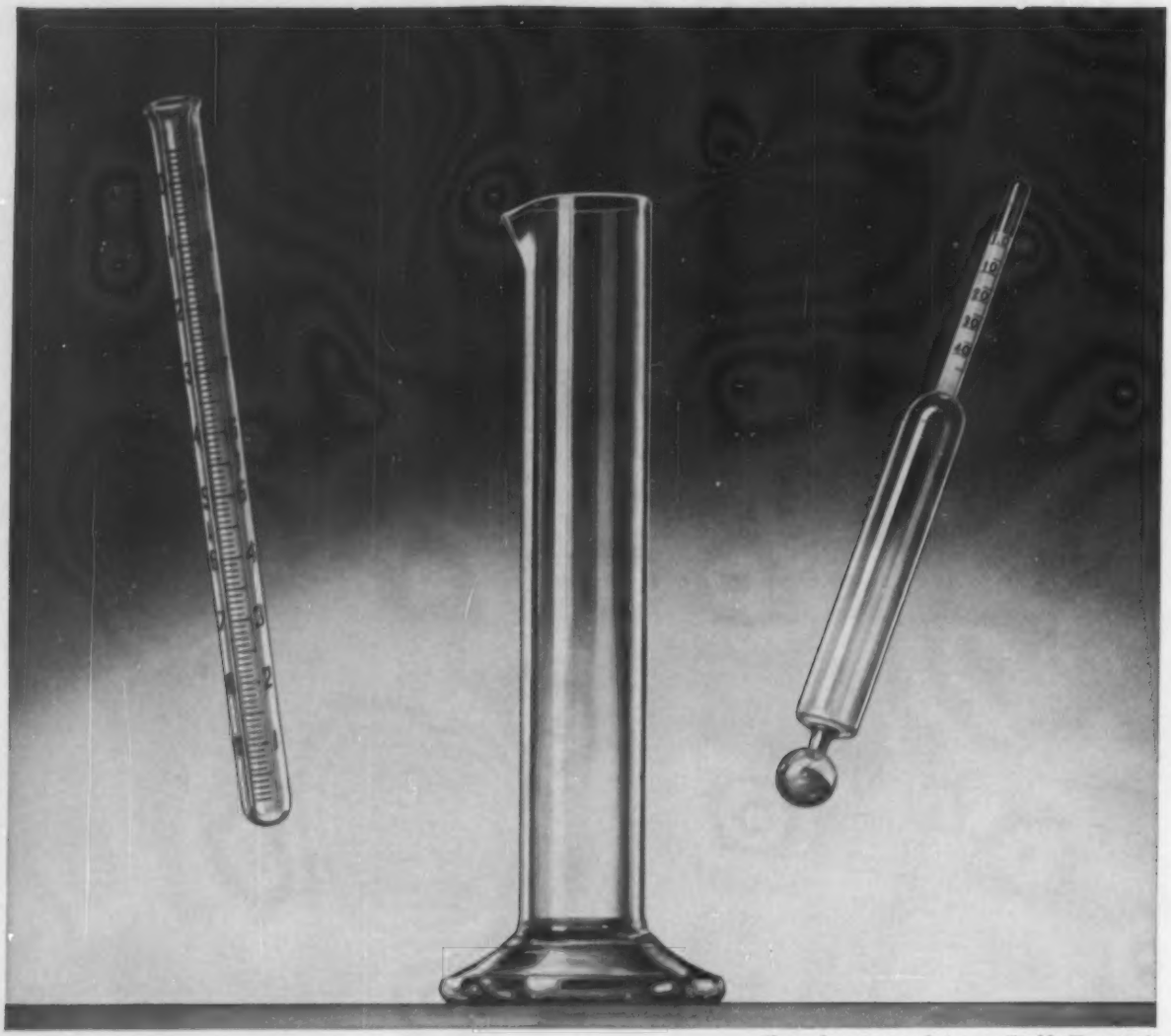
Mail this coupon today!
We are interested in receiving Bulletin C-108, descriptive of the American Hypodermic Needle Cleaner.

Name _____

City _____ State _____

For attention of _____

AMERICAN STERILIZER
Erie 6 · Pennsylvania



Shown here in actual size are Kimble Hematocrit Tube #46749, Glasco SMALL Urinometer Set #765.

For dependable serological and urine tests specify these GLASCO laboratory items

KIMBLE HEMATOCRIT TUBES:
You'll never worry about "losing" the calibrations on these new Hematocrit tubes. Kimble uses a "color filler" that is as resistant to chemical attack as the glass itself. Graduated scales will never become illegible, regardless of the way the tubes are washed or handled.

GLASCO SMALL URINOMETERS:
Now you can use as little as 15 ml. of urine with complete test accuracy. The heavy glass foot of the cylinder is accurately leveled by grinding and insures against easy tipping. The mercury-filled hydrometer is retested to allow a maximum tolerance of plus or minus .002 specific gravity. It remains stable and upright even in solutions where specific gravity is close to 1.000.

Every Hematocrit tube and urinometer is individually tested and retested to be sure of its accuracy. All are thoroughly annealed to increase mechanical strength.

There is a Glasco item for every laboratory requirement. Order from your hospital supply house, or write direct to us for a free copy of our latest catalog and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS



After using salt throughout life --

— it's a pretty hard blow to be told:

"No salt on anything *from now on!"*

To help your patient over this hurdle —

Neocurtasal®

Salt without Sodium



gives an appetizing tang to flat, salt-free diets. Completely sodium-free, Neocurtasal brings out the flavor of unsalted foods.

Wherever sodium restriction is indicated, Neocurtasal may be safely prescribed to keep the patient on the low sodium diet.

Neocurtasal is available in 2 oz. shakers and 8 oz. bottles.

WINTHROP

Write for pad of low sodium diet sheets.

CONSTITUENTS: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate, potassium iodide (0.01%) and starch.

Winthrop-Stearns INC. New York 18, N. Y. Windsor, Ont. Neocurtasal, trademark reg. U.S. Pat. Off.

We have changed our name to **WINTHROP LABORATORIES INC.**
Only the name is changed—nothing else.



when a minute's delay can cost a LIFE!



St. Vincent's Memorial Hospital, Taylorville, Illinois
Architects—Hadley & Worthington, Springfield, Illinois;
Engineer—Consulting Engineer Service, Champaign, Illinois;
Heating Contractor—Davis Construction Co., Chicago, Illinois

KEWANEE reserve plus rated boilers

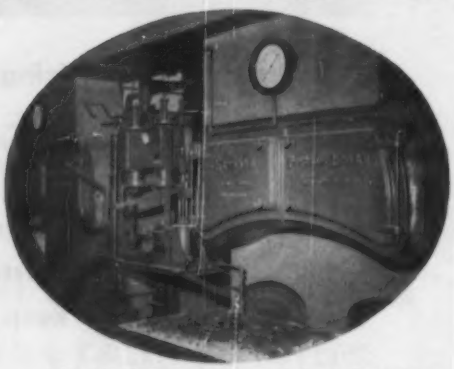
. . . stand on guard against power failure

"Calling Dr. Caldwell! Calling Dr. Caldwell! Emergency Operating Room!"

Throughout the corridors of hospitals daily come urgent calls, rushing men of mercy to the task of saving lives. And those men know there must be no failure of equipment . . . no delay when life is at stake.

That *is* why hospitals like St. Vincent's Memorial Hospital and their architects chose with care when it came to boilers. They knew the need of reserve power when emergencies must be met. So, they installed Kewanee Reserve Plus Rated Boilers, certified to deliver 50% extra reserve power . . . that added measure of protection always on call no matter what the need. For Kewanee Boilers are rated on nominal capacity to operate at "cruising speed" with "standby power" immediately available any time. You can be sure there will be no power failure if you follow the Kewanee Reserve Plus Rating Plan in considering boilers. Know these important facts:

1. Boiler rating *must be* based on nominal capacity, not maximum capacity;
2. Boilers *must have* sufficient built-in reserve to meet changing demands;
3. Boilers *must have* sufficient capacity to operate at "cruising speed," not maximum speed at all times;
4. Like examples *must be* considered in comparing boilers. Don't be confused by vague technical claims.



2 No. 587 125-lb. Firebox Steam Boilers for Stoker firing used at St. Vincent's Memorial Hospital. Power failure is no worry here because these boilers have reserve to meet every need.





MOSAIC® **Ceramic Tile in the new Metropolitan Hospital,**

a project of the Dept. of Public Works, City of New York; Frederick H. Zurmuhlen, P.E., R.A., Commissioner; Albert B. Bauer, Director, Div. of Bldg.

CHAS. B. MEYERS, ARCH. · A. TOZZINI TILE WORKS, INC., TILE CONTR. · HEEFER-MAYO, PHOTO



(A) Operating Rm.—Floor: Impervious Electrically Conductive Ceramic Mosaic Pattern 1778-A3. Wainscot: 9"x6" x ½" Wall Tile.
(B) Recovery Rm.—Floor: Ceramic Mosaic Pattern 1778. Wainscot: 9" x 6" x ½" Wall Tile.
(C) Patient's Bath—Floor: Granitex Pattern 1779, S. E. Tub: Granitex Pattern 1780, S. E. Wainscot: 4¼" x 4¼" Wall Tile and Granitex Pattern 1780, S. E.

Select the right tile for every hospital area from the only complete ceramic tile line. . . . .

America's largest ceramic tile manufacturer



THE MOSAIC TILE COMPANY

Gen. Offices: Zanesville, Ohio. Member: Tile Council of America and The Producers' Council, Inc.

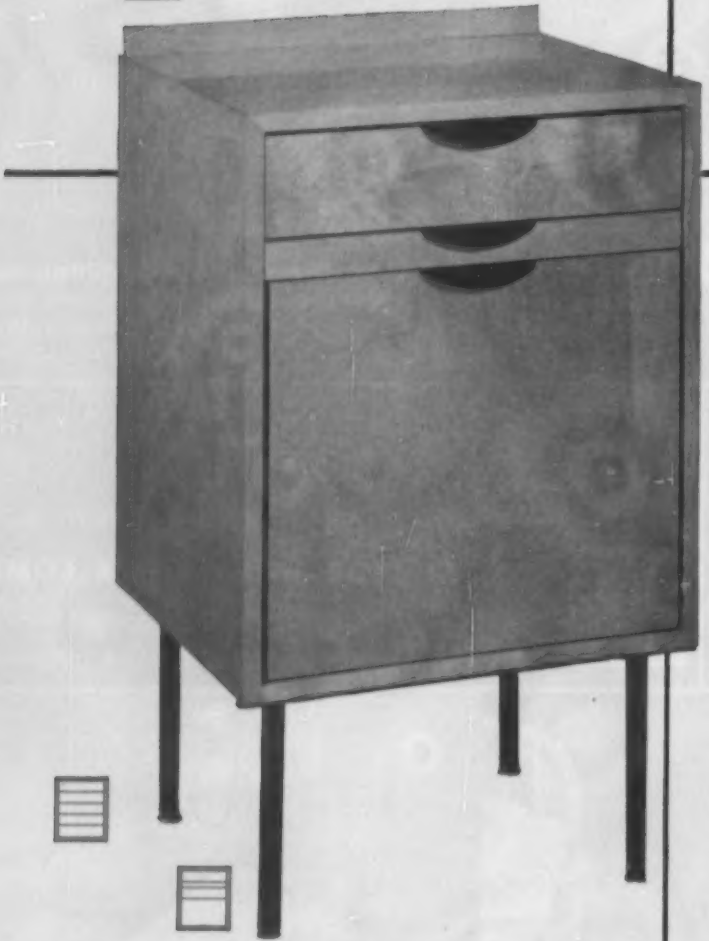
Factories, Showrooms and Warehouses from Coast to Coast





New...

KALEIDOSCOPE FURNITURE





Featuring

72 Combinations of the Kaleido-Kase

Here's a new idea in hospital furniture! It's KALEIDOSCOPE . . . a complete patient room grouping that includes the KALEIDO-KASE, a most versatile unit. The KALEIDO-KASE is a bedside cabinet, a chest or a combination of both. Actually provides 72 possible combinations . . . one or more of which is sure to meet your exact needs. Large or small rooms, single, double or ward . . . this is the answer to every furnishing problem. You can now have flexibility of room arrangement and interchangeability of pieces from room to room!

CARROM INDUSTRIES, INC.

Ludington, Michigan



Write for New Catalog!

See the 72 KALEIDO-KASE combinations! See the complete KALEIDOSCOPE Grouping! Send for this Carrom catalog now.

by **Carrom**



TYPICAL of the KALEIDOSCOPE grouping is this **CARROM - 2 - HEIGHT** Bed . . . electric or manual. The grouping also includes easy chairs, side chairs, overbed tables and flower tables.



Above, washroom of 703-bed Albany Hospital's mechanized laundry department. Shown, one (of two) 60″ Notrux Extractor; five 42 x 96″ Cascade Unloading Washers with Full Automatic Controls; 42 x 24″ Cascade Washer; 30″ Extractor. This is just a part of the automatic laundry equipment reducing operating costs $18,500 a year.



A great aid to increasing production 100% is this 48 x 84″ Rotaire Conditioning Tumbler (right), with conveyors feeding large and small linens to two 8-Roll Streamline Flatwork Ironers, one equipped with a Sager Spreader.



Operator morale hit a new high when these Trumatic Folders were installed on the two Streamline Flatwork Ironers in Albany Hospital's laundry. This automatic equipment saved labor and put linens back into service faster.

Albany Hospital saves $18,500 a year by mechanizing laundry

A new laundry was in store for 703-bed Albany Hospital, Albany, N.Y., as a part of their overall expansion and modernization program. The administrators, realizing the importance of automatic labor-saving equipment, wanted the best for their new laundry. They called in an American Laundry Consultant to make a complete survey of their new laundry requirements.

They readily saw that only American could supply them with *complete* laundry facilities with emphasis on automatic equipment. Now, Albany Hospital has a completely modern, American-equipped laundry which produces highest quality work . . . faster. Benefits? Quicker return of linens to service. Production increased 100%. Savings of $18,500 a year in labor alone!

Whether you are planning a new laundry, or the modernization of present facilities, it will pay you to get the advice of your American Laundry Consultant before you make your first move. His expert services are available to you *without* cost or obligation.

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment



You can depend on your American Laundry Consultant's advice in your selection of equipment from the *complete American Line*. Backed by our 87 years experience in planning and equipping laundries, he can help solve your clean linen problems. Ask for his specialized assistance anytime . . . no obligation.

American

The American Laundry Machinery Company, Cincinnati 12, Ohio



...just call on "Rex" McKay!®

When the busy hospital pharmacist needs a new and possibly unfamiliar pharmaceutical, McKesson's "Rex" McKay service is invaluable... just contact your nearest McKesson Division. "Rex" will have the answer! Another thing—your local McKesson representative is your assurance of these services.

1. **COMPLETE STOCKS... YES!** You can be assured that McKesson carries the most complete line of pharmaceuticals available.

2. **FAST DELIVERY... YES!** No matter where you are located, there's a McKesson wholesale division nearby to service your needs.

3. **PERSONAL SERVICE... YES!** The McKesson representative calls on you at regular intervals, and in emergencies a telephone call to the McKesson Division nearest you will provide rush shipments.

4. **LESS DETAIL... YES!** You have only *one* invoice when you order through McKesson... only *one* shipment to open and check... only *one* representative to see.

If a McKesson representative is not calling on you at present, or if you want more information, write to McKesson & Robbins, Incorporated, 155 E. 44th St., New York 17, N. Y.

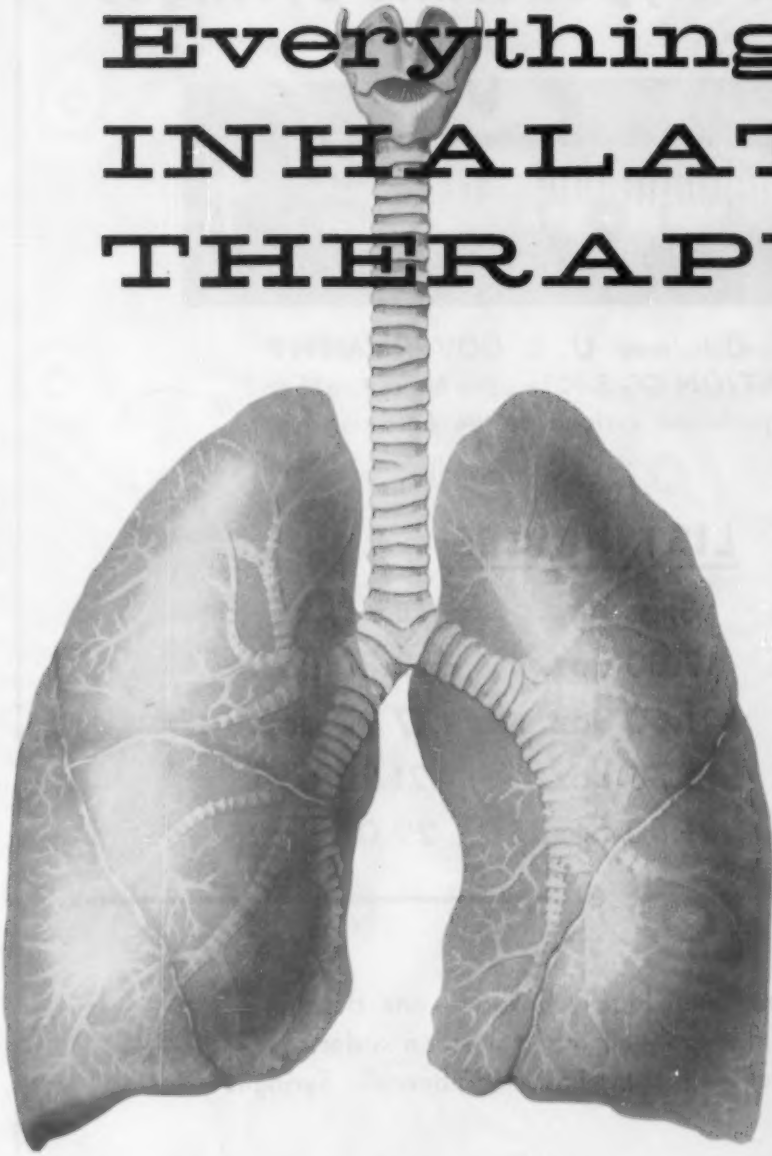
McKESSON & ROBBINS
INCORPORATED

74 Completely Stocked Warehouses from Coast to Coast

From One Source

Everything for INHALATION THERAPY

. . . everything on one monthly statement!



THERAPY OXYGEN
U.S.P. oxygen in all standard cylinder sizes, or in bulk supply units for piped systems. Distributed through NCG district offices in 56 principal cities and through authorized NCG dealers . . . in the manner that is most convenient for you.

MEDICAL GASES
Oxygen, Oxygen-CO_2 Mixtures, Helium, Helium-O_2 Mixtures, Carbon Dioxide, Nitrous Oxide, Ethylene, Cyclopropane.

TENTS AND CANOPIES
The famous *Plymouth*® Oxygen Tent, the new *Plymouth* Jr. Oxygen Tent with built-in nebulizer, the Iceless Oxygen Tent, and a wide choice of permanent-type, semi-permanent, or disposable tent canopies.

NEBULIZERS
The definitive line of nebulizer units and nasal equipment for high-humidity oxygen therapy. In NCG nebulizers, 97% of the particles nebulized are 3 microns or less in diameter.

MASKS AND CATHETERS
Face masks, tracheotomy masks, laryngectomy masks, catheters, cannulas, connecting tubings in permanent or disposable type plastics.

REGULATORS
Precise performance at low cost, with all the great construction features that make NCG regulators outstanding for long, trouble-free service.

ACCESSORIES
Oxygen analyzers, tubing splicers, connectors, needle valves, liter gauges, adaptors, wrenches, cylinder trucks, cylinder stands . . . *everything* you need for complete and effective inhalation therapy service.

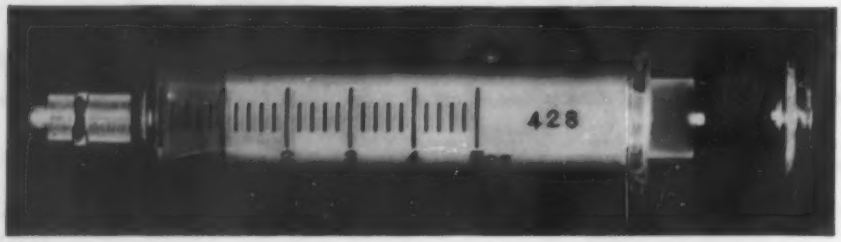
RESUSCITATORS
For use with piped oxygen systems, and all standard regulators and cylinders. Portable models for ambulance service. Floor stand models for emergency use throughout the hospital.

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All our Hypodermic Syringes



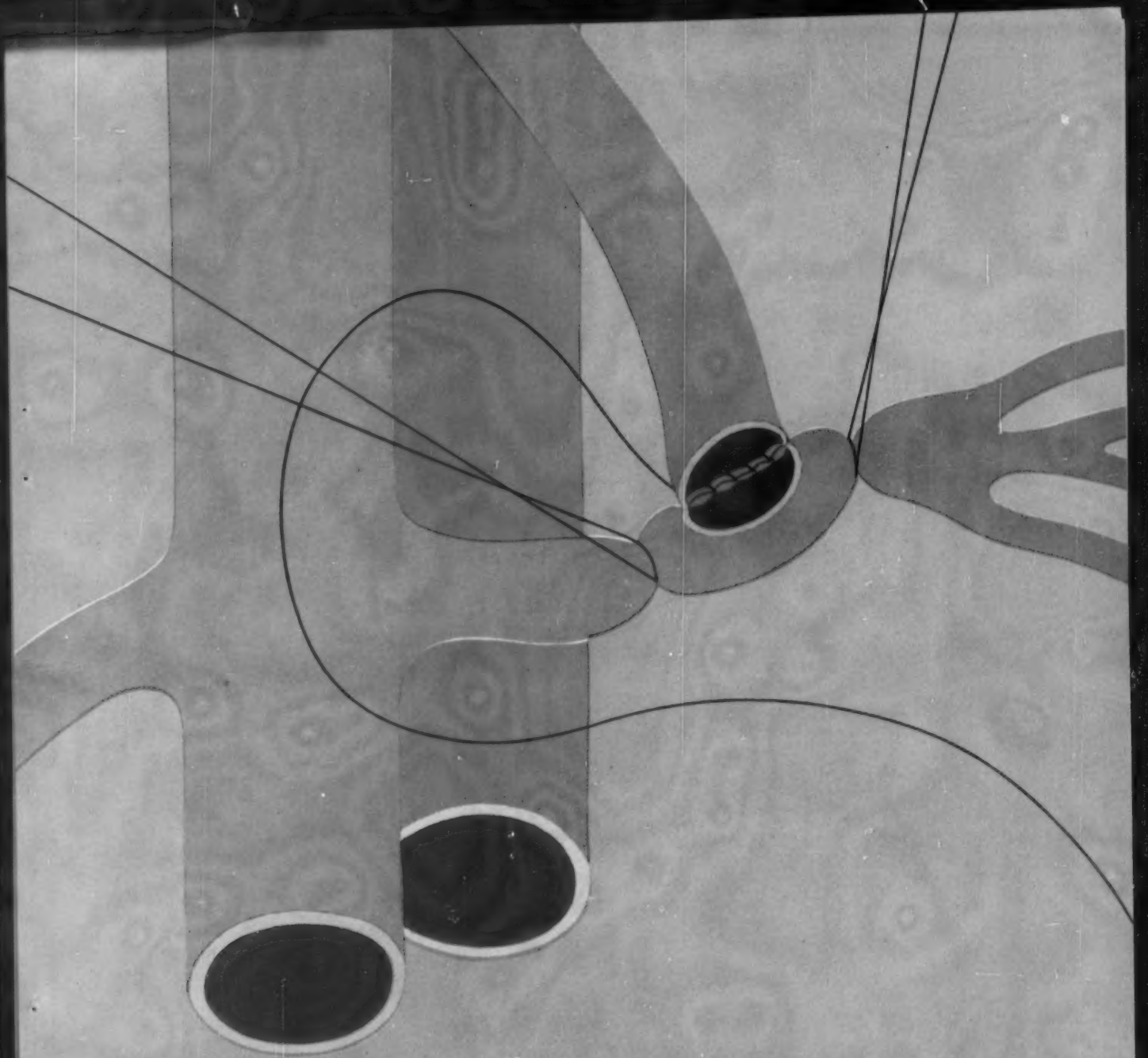
are guaranteed to meet ***U. S. GOVERNMENT SPECIFICATION*** *GG-S-921a. The highest caliber imported hypodermic syringe at the following:*

LIST PRICES

Size	Glass-Tip	Luer-Lock
2 cc	$9.00 doz.	$12.80 doz.
5 cc	11.60 doz.	17.00 doz.
10 cc	15.70 doz.	21.20 doz.
20 cc	21.50 doz.	29.00 doz.

Each syringe individually boxed — one dozen to a container — all other sizes on order.
Complete Stock — 1cc Insulin and Tuberculin Syringes

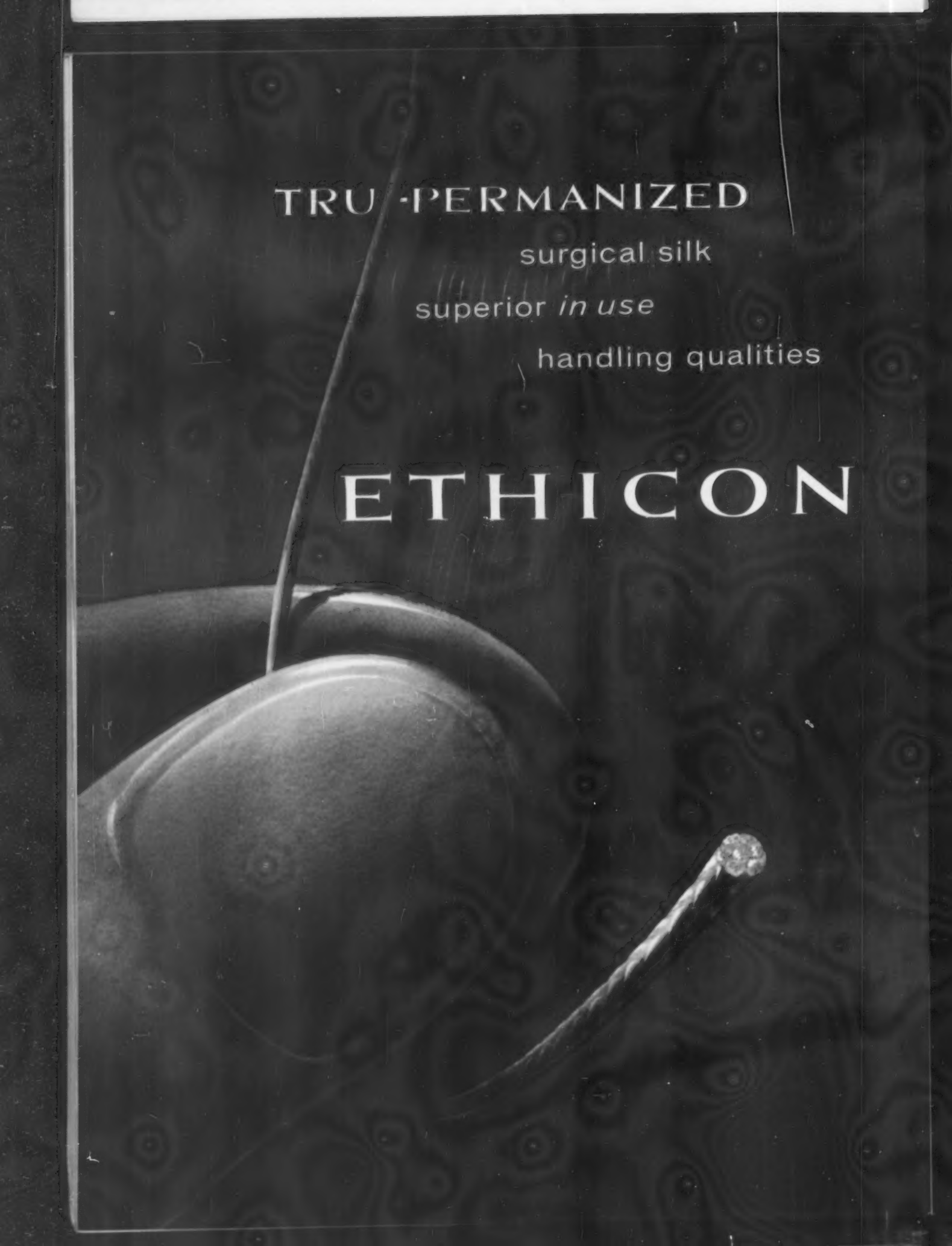
MERCER CHEMICAL CORP.
11 MERCER STREET · NEW YORK 13, N. Y.
Telephone: WOrth 4-4540

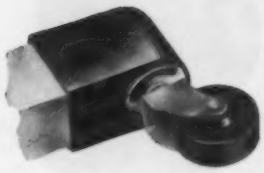


setting new standards

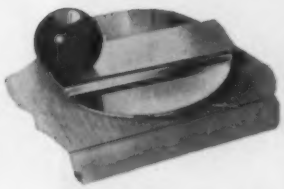
ETHICON®

sutures

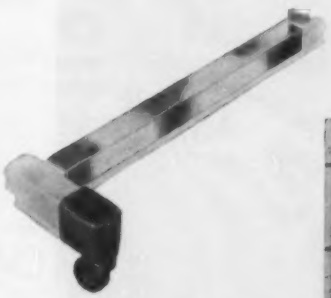

TRU-PERMANIZED
surgical silk
superior *in use*
handling qualities
ETHICON



All four legs (walls and other furniture, too) protected by rubber bumpers like these. Notice that these bumpers are a built-in, intricate part of the table — cannot be lost.



Crank handle is on top of table for ease of operation, yet is designed so as not to snag attendant's clothing or the bedding.



Stainless steel scuff plate reduces maintenance costs by protecting finish from scuffing. (Optional)



Patients appreciate the easy, double-action of this center section which adjusts to three different angles on each side. Exclusive safety feature prevents mirror from accidentally falling or being knocked flat — an accident which might break the mirror or the patient's fingers.



NEW HARD ⑤ FEATURE OVERBED TABLE

Like every piece of Hard Hospital Furniture, this overbed table meets *all* five hospital requirements.

HARD ⑤ FEATURE HOSPITAL FURNITURE

Every piece of Hard hospital furniture is built around ⑤ specific features. ① **SAFETY** for both patients and attendants alike. ② **EFFICIENCY** — designed to do its job efficiently, including both ease of use by attendants and convenience and comfort of patients. ③ **EASE OF MAINTENANCE** — resulting from thoughtful design, sturdy construction, durable, chip-resistant finishes and intelligent use of scuff plates and bumpers. ④ **STYLING** — pace setting styles that make the Hard line the most attractive, most practical and most comfortable in the entire industry. ⑤ **GUARANTEE** — Hard's 75 years of experience plus its reputation for top quality is your best guarantee of hospital furniture.

Every piece of Hard ⑤ Feature Hospital Furniture has been designed with the help of the Hard Panel of Hospital Experts. This panel made up of administrators, doctors and nurses carefully check every Hard design and every new Hard product. Panel approval assures you that every piece of Hard hospital furniture meets *every* hospital requirement. When you equip with Hard hospital furniture, you follow the lead of outstanding hospitals the country over.

HARD MANUFACTURING COMPANY
BUFFALO 7, NEW YORK

Shown below is Hard's ⑤ Feature Omega Room Group



. . . like protection against accidents.

Yet protection alone isn't enough. We must always be alert to avoid accidentally harming ourselves — *or others.* Accidents are one of the nation's most sinister killers. Guard against the one accident that may ruin a life: *be careful — the life you save may be your own.*



. . . like pure ethyl alcohol in our hospitals.

Yet how widely it is used for everything from an alcohol rub to a therapeutic nerve block. How unvarying in purity and dependable in supply. U.S.I. is proud to play a part in making ethyl alcohol U.S.P. something you *can* take for granted.

THINGS WE TAKE FOR GRANTED



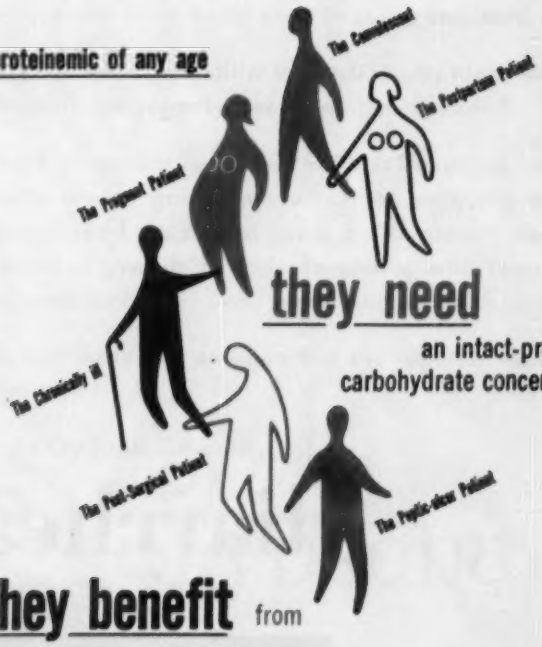
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INDUSTRIAL CHEMICALS CO.

Division of National Distillers Products Corporation

U.S.I. pure alcohol U.S.P.

The hypoproteinemic of any age



they need

an intact-protein, carbohydrate concentrate

they benefit from

Protinal*

NATIONAL

Micropulverized casein powder (61.25%), Carbohydrate (30%) to maintain protein/carbohydrate equilibrium essential for tissue regeneration.

COMPLETE PROTEIN

COMPLETELY PALATABLE

VIRTUALLY FAT AND SODIUM FREE (Less than 0.03% Na, Less than 1.0% Fat)

The National Drug Company Philadelphia 44, Pa.

Available: Delicious in either vanilla or chocolate flavors, in bottles of 8 oz., 1 lb., 5 lb., and 25 lb. containers.

*VI-PROTINAL—Palatable whole protein-carbohydrate-vitamin-mineral mixture of high biological value

Upjohn

diarrhea...

Kaopectate

Trademark Reg. U.S. Pat. Off.

Each fluidounce contains:

Kaolin . . . . . 90 grs.

Pectin . . . . . 2 grs.

in an aromatized and carminative vehicle

Available in bottles of 6 and 10 fluidounces and 1 gallon

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



now every surgeon can obtain "Gypsona"

the world's most widely used plaster of Paris bandage

"Gypsona" bandages – long known as quality bandages – are now available to every physician in the United States. Originally developed in England, this bandage – made with a unique type of gypsum – has been used in every continent of the world.

To make "Gypsona" conveniently available in the U. S. A., plant capacity and distribution facilities in the States have recently been greatly expanded.

"Gypsona" is the hallmark of quality in plaster of Paris bandages because they are constructed from a specially woven gauze into which the unique gypsum is heavily, yet finely and evenly impregnated by a special process. "Gypsona" bandages contain just the right weight proportion of gypsum to cloth, to obtain, with fewer bandages, lighter yet exceedingly strong casts with a smooth, porcelain-like finish, and long wear.

True, "Gypsona" casts cost more per package but the superior functional performance effects an over-all economy.

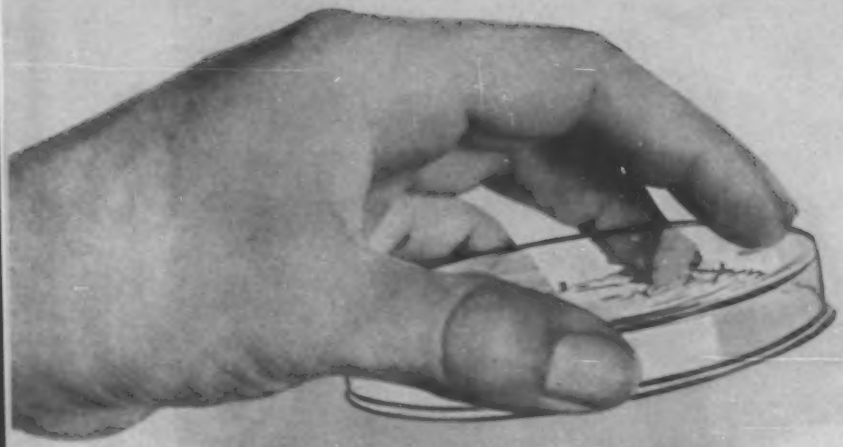
That is the essence of quality achieved with . . .

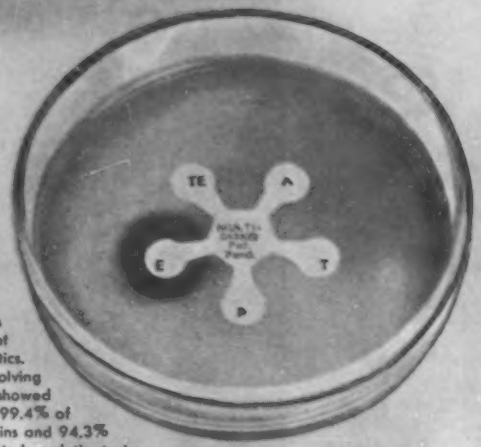
Gypsona*

S&N SMITH & NEPHEW, Inc., 137 East 25th St., New York 10, N. Y.

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DESTROYS ENTEROCOCCI

This blood agar plate shows a strain of *beta* hemolytic enterococcus. Note extreme sensitivity of this organism to ERYTHROCIN—yet it easily resists the other antibiotics. Additional data: A study[1] involving 202 enterococcic strains showed sensitivity to erythromycin in 99.4% of *alpha* hemolytic strains and 94.3% of *beta* hemolytic strains.

specific against coccic infections

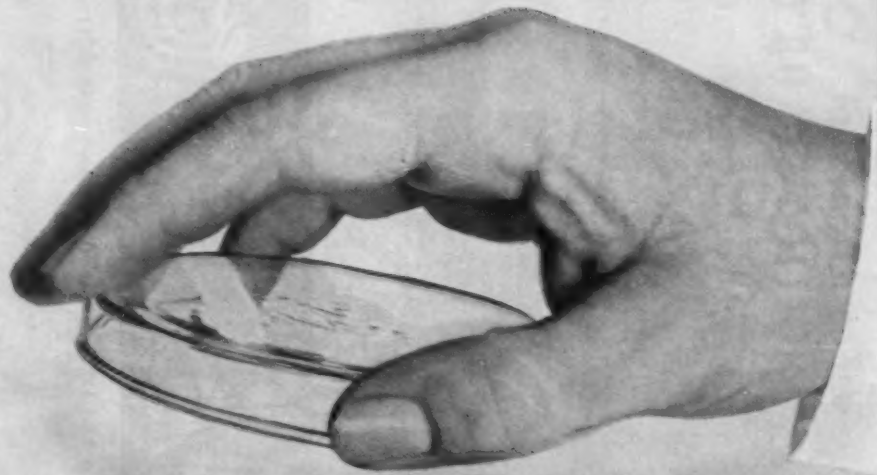
Now, you can prescribe *specific therapy* against staph-, strep- or pneumococci by simply writing *Filmtab* ERYTHROCIN Stearate. Since this coccic group causes most bacterial respiratory infections (and since these organisms are the very ones most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe *Filmtab* ERYTHROCIN when the infection is coccic?

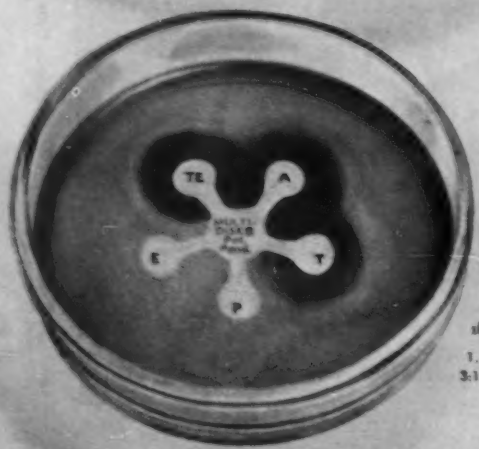
filmtab®

Erythrocin®

Erythromycin Stearate, Abbott)

STEARATE





SPARES
INTESTINAL FLORA

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect this gram-negative organism—although the other antibiotics show marked inhibitory action.

1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.) is supplied in bottles of 25 and 100 at pharmacies everywhere. Abbott

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Erythrocin®

(Erythromycin Stearate, Abbott)
STEARATE

® Filmtab—Film coated tablets; patent applied for.

509183

to Mr. Purchasing Agent

FOR THE COURAGE TO CHANGE... FOR THE BETTER!





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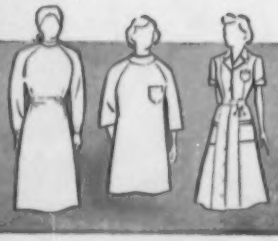
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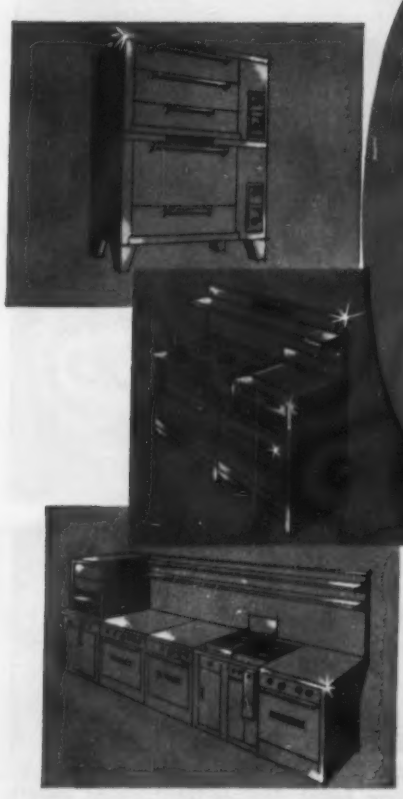
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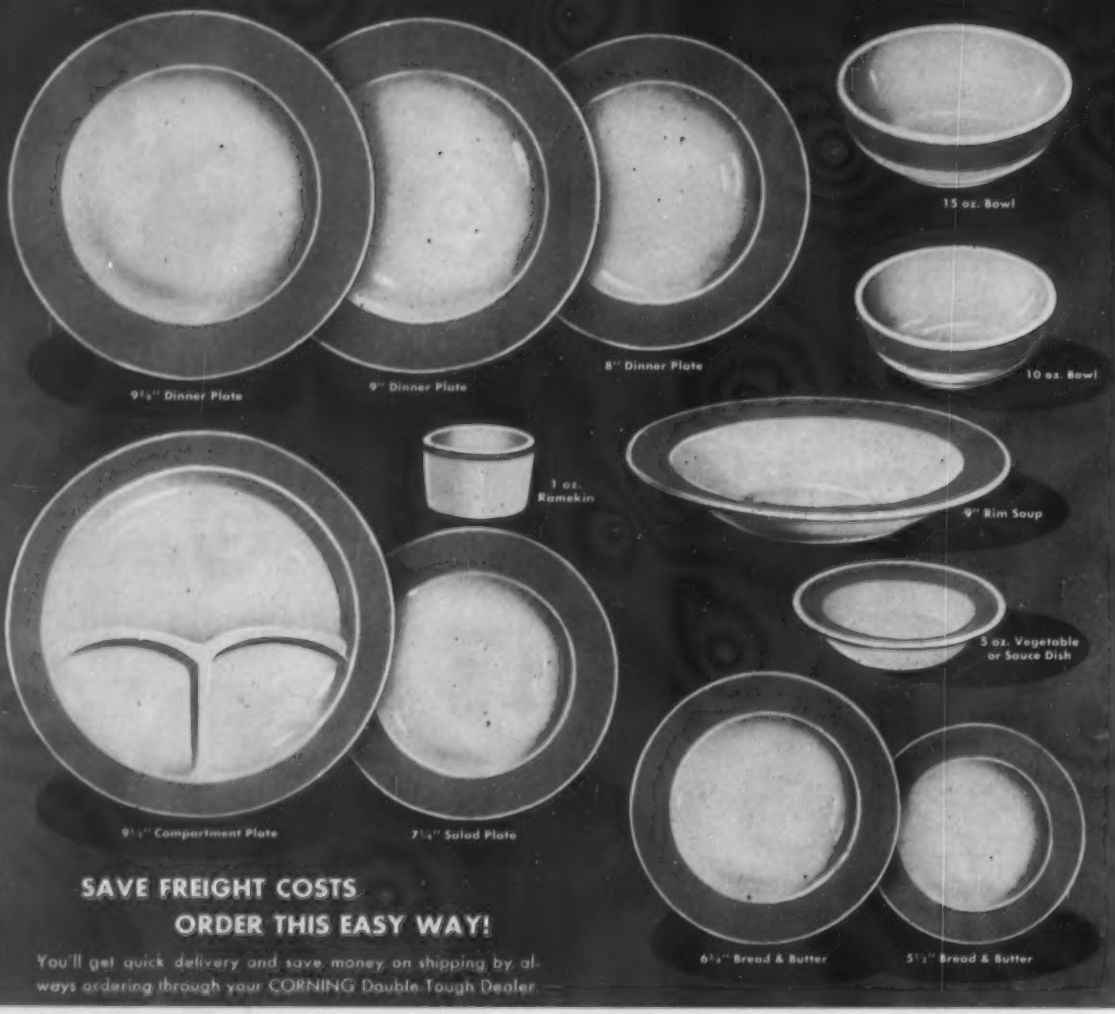
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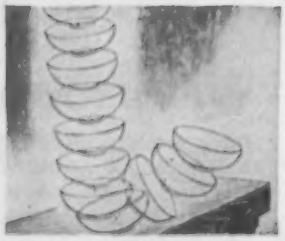


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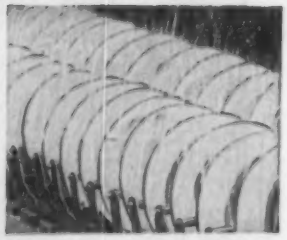
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SMALL HOSPITAL QUESTIONS

Percentage of Profits

Question: Where can I get some information about average percentage of profits in the x-ray and laboratory departments? I have done some studies and find that the laboratory expenses run about 6½ per cent of the total and the x-ray expenses run about 8½ per cent of the total. Payments to the department heads are included in these figures. Both department heads are paid on a commission basis. The radiologist gets roughly 38 per cent of the gross business, and the pathologist gets 40 per cent. If I divide the difference between income and direct expense in these departments by the gross income, I find a theoretical profit figure of 14 per cent in laboratory and 34 per cent in the x-ray department. If overhead were added to the expenses of each department, the profit figure would be much lower.

I am of the opinion that both of these departments, that is, the heads of both, are being paid a commission somewhat out of line with the hospital's share. I believe that their contracts should be reviewed with the thought in mind that the hospital is not realizing enough net income from these departments.—F.A.R., Mich.

ANSWER: There are no published figures on the profits earned by x-ray and laboratory departments of hospitals, and we would suggest the only way to accumulate information of the kind you are seeking would be to write directly to hospitals asking for their individual experience in these departments. Generally speaking, the 38 per cent of gross income for the radiologist and 40 per cent of gross income for the pathologist represent the objectives sought by members of these groups in their negotiations with hospitals, and in their professional associations. Many hospital people, however, feel it is sounder to pay a percentage of the net rather than of the gross receipts. Using a percentage of net profits permits the hospitals to include all direct costs, plus an honest, reasonable allocation of overhead, including proper depreciation and obsolescence charges, providing a true cost figure. Some hospitals offer a combination of salary and percentage of the net profit, but, of course, the salary is opposed by professional organizations and many of the individuals in these groups.

Your "theoretical profits" of 14 per cent and 34 per cent in these departments would unquestionably be substantially reduced if indirect, as well as direct, expenses were included. In fact, it is perfectly possible you are losing, rather than making, money in these departments under the present arrangement. Only a detailed cost analysis of the departments would reveal the facts.

TV Sets Have Appeal

Question: Should we install television sets in the patients' rooms of our new addition? We have been told this is being done to advantage in some new hospitals, even that the sets are recessed in walls. What about the noise factor? What about costs?—C.B., Okla.

ANSWER: Such installations have been made in several new hospitals, and in many others the sets themselves have not yet been installed, but all the necessary wiring and cable were put in at the time the structural work was being done, so the actual sets could be installed easily and economically as soon as the hospital could afford them.

Where planned installations of the kind you refer to have been made, the sets are generally installed fairly high on the wall opposite the patients' bed, with provision for remote control of the set. The tremendous popularity of television in the United States now would indicate that the hospital which can afford these installations should plan to have a few, at least, for patients requesting television facilities. In most cases, an additional, reasonable charge can be made to cover the cost of operating and maintaining the sets and, eventually, recover the installation costs as well. If feasible, it might be wise to make a survey among a representative group of recent patients to determine (a) how many would use television if it were available, and (b) whether the charge the hospital would have to make to recover installation and operating costs would be within the means of the interested patients. Noise has not been a serious problem in most hospitals providing television service.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Is Psychiatric Unit Feasible?

Question: The council of social agencies in our community has urged trustees of the hospital to establish a service for mental patients. Is this being done commonly in hospitals of 100 beds?—J.V.C., Calif.

ANSWER: The answer depends on the organization of medical services in the community, and the availability of adequate facilities for private hospital care of mental patients in the area. Only one hospital in 25 in a survey conducted by the U.S. Public Health Service two years ago provided service for patients with nervous and mental diseases.

Nursing Personnel Salaries

Question: Are there any figures on the average salaries paid for graduate nurses, practical nurses, and untrained nursing help in 50 bed hospitals outside our larger cities?—P.S., Mass.

ANSWER: The average salaries paid to graduate general duty nurses in a group of hospitals of this size studied recently was $223 a month. The average for practical nurses in this group was $157 per month, and the average for untrained nursing help was $122 per month for women and $151 for men.

Separate These Jobs

Question: We are considering separation of the storeroom and acquisition functions of the purchasing department which, up to now, have been under our purchasing agent. I would be interested in knowing whether you consider it advisable to undertake such a separation.—L.F., Mo.

ANSWER: This question is one that can be argued in all directions for a long time. However, if the hospital is of sufficient size, it seems best to separate the functions of purchasing agent and storeroom manager and have them report independently to the administrator, an assistant administrator, or the business manager.—E.W.J.

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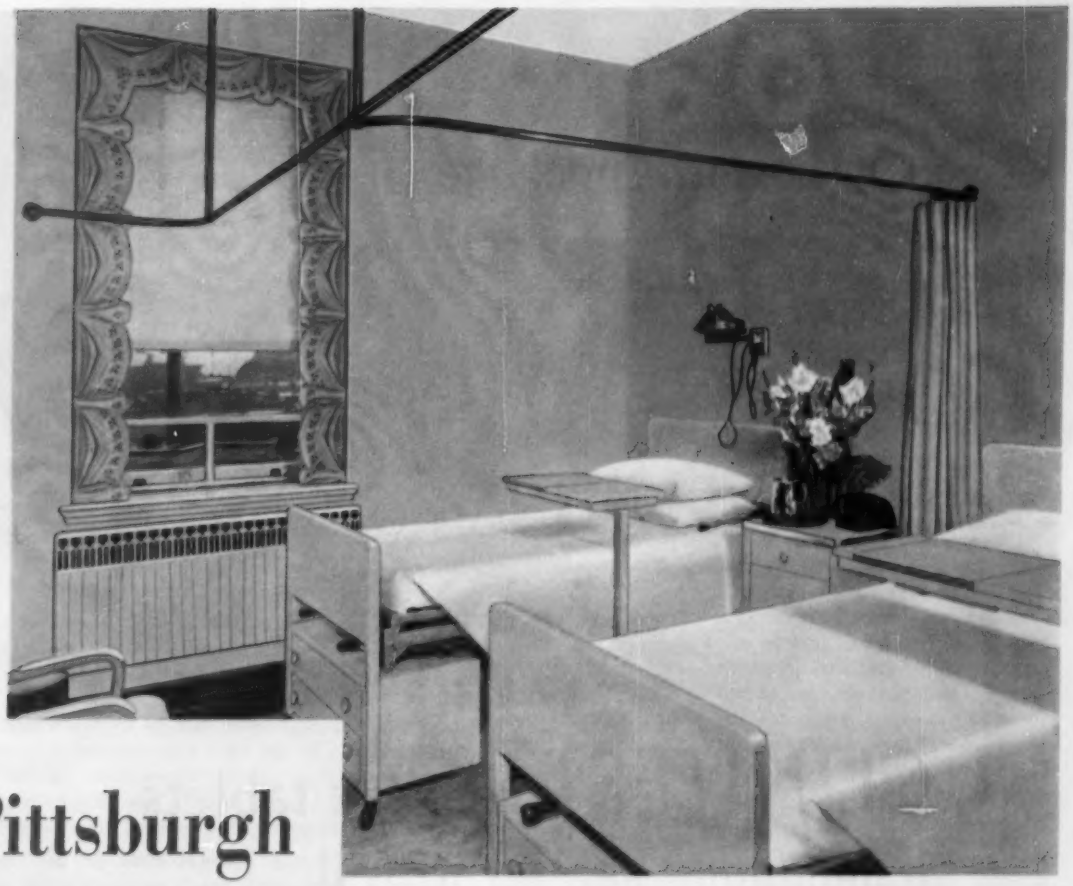
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Judge Rules Against Iowa Hospitals

Under existing arrangements, Judge Moore rules, hospitals and specialists are both guilty of violating Iowa law against secret division of fees; hospitals also violate medical practice act

DES MOINES, IOWA.—Polk County District Judge C. Edwin Moore ruled November 28 that it is illegal for Iowa hospitals to employ physicians and charge patients for their services.

The ruling, based on evidence received during the 13 week trial of the Iowa hospital-physicians lawsuit in Judge Moore's court, generally upholds the contention of Iowa's attorney general and of the Iowa State Medical Society. The lawsuit was filed by the Iowa Hospital Association and 34 member hospitals as a court test of a 1954 attorney general's opinion that hospitals hiring such medical specialists as pathologists and radiologists and billing patients for their services are practicing medicine illegally.

Attorneys for the Iowa Hospital Association said here that Judge Moore's decision almost certainly will be appealed to the Iowa Supreme Court.

The ruling has national importance for hospitals and medical specialists. In effect, it condemns a relationship that has existed between hospitals and doctors in Iowa for 50 years and in other states for a longer period, officials stated.

In most instances, radiologists and pathologists today work in hospitals on a salary or percentage basis. Hospitals usually bill patients for the services of these physicians, but seldom use the name of the physician on the bill. Judge Moore ruled that this practice constitutes the illegal practice of medicine by the hospital.

Judge Moore said his ruling means that:

"Hospitals cannot employ medical specialists on a salary or percentage arrangement."

Patients must be billed for the professional services of the pathologist and radiologist in the name of the physician. The hospital may act as the physician's collection agent, but in such cases the physician's name must appear on the hospital's statement.

Hospitals legally can charge patients for the use of facilities provided by the hospitals in the pathology and radiology departments. In this event, the physician would submit a separate bill to the patient for professional services.

The hospital legally can lease space, equipment and other facilities to the physician. This lease can provide for payment of a flat sum or a percentage of the departmental income, provided the payment is from the physician to the hospital.

Physicians may own the equipment in the pathology or radiology departments if they so prefer.

Laboratory technicians may be employes of either the hospital or the physician. Details of the status of these technicians, as well as details of financial arrangements between doctors and hospitals, are to be worked out at the local level.

Attorneys for the Iowa Hospital Association argued during the lengthy trial that nonprofit hospitals should be exempted from the legal rule against the corporate practice of medicine. Judge Moore, however, found that "most of the reasons given in the [cited legal] decisions condemning corporate practice generally are applicable to the nonprofit corporations." He added:

"The law applies to all and must not be violated even if the intention is only to do good." The Iowa Hospital Association attorneys also argued that there was "strong evidence" of the legality of present hospital-specialist relationships because of their lengthy history.

Judge Moore commented in his ruling that "the failure of those charged with the enforcement of the law cannot write an exclusion to the provisions of the law."

He added that the hospitals "are not entitled to operate pathology and x-ray laboratories merely because they have done so for many years, nor has the court the right to indulge in judicial legislation. The law is established and if there is a change it is for the legislature and not this court. If the nonprofit corporations operating hospitals are to practice medicine it is for the legislature to say by proper legislation."

The pathologist and radiologist who permits "a hospital to bill for medical services in the name of the hospital without the consent of the patient" is violating a state law prohibiting the secret division of medical fees, Judge Moore ruled. He also ruled that "the work done by the pathologist, radiologist and the technicians working in the pathology and x-ray laboratories constitutes the practice of medicine."

He added: "Under Iowa law the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation."

"Both the hospitals and physician specialists," Judge Moore concluded, "have been violating Iowa law."

The hospitals, his ruling said, "have been engaged in the unauthorized, unlicensed and illegal practice of medicine.

(Continued on Following Page)

"And the pathologists and radiologists have been violating the provisions of Iowa law prohibiting the secret division of professional fees."

At the end of his 32 page ruling, Judge Moore noted:

"It is the opinion of the court that the furnishing of proper pathology and x-ray services to the patients in the hospitals can be worked out on the local level and within the law."

He directed that the costs of the lengthy trial should be levied against the Iowa Hospital Association.

That association maintained during the trial that the work of pathologists and radiologists should be regarded as hospital services provided by the hospital to the medical staff.

The Iowa State Medical Society and other defendants in the lawsuit argued that the work of these physician-specialists constitutes medical service. The pathologists and radiologists, according to this view, are consultants of attending physicians and have an ethical obligation to bill patients directly for their services.

Judge Moore upheld this contention of the Iowa State Medical Society.

Defendants in the Iowa Hospital Association lawsuit filed last January included the Iowa attorney general's office, the Iowa State Board of Medical Examiners, and the Iowa Association of Pathologists. The Iowa State Medical Society entered the case as intervenor on the side of the defendants.

(FOR EARLIER STORY, SEE PAGE 72)

wire from Washington

HOOVER COMMISSION ACTION

Behind the scenes in Washington some pressure is being built up to get action on the Hoover Commission's recommendations, including many in the health and hospital fields. There is not much possibility that the Congress will be bowled over by the movement, but the promotion is being handled carefully and intelligently and it may meet with success here and there.

Heading it up is Meyer Kestnbaum, chairman (1953-54) of the Commission on Intergovernmental Relations, which did a scholarly job of appraising the relative rôles of the federal, state and local governments in activities in which all are involved, such as Hill-Burton and other grants.

Kestnbaum has the advantage of not working on the outside but of being attached to the White House as special adviser to the President. It is his job to induce federal officials and departments to put into effect those seemingly noncontroversial recommendations of the Hoover Commission that do not require action by Congress. Here the greatest obstacle is admittedly inertia, which is a problem in official Washington regardless of the party in power.

Part of the strategy is to prevail on each secretary and administrator to make one person in his department or agency responsible for following up on the recommendations. Some departments have these expediters already functioning; other agencies haven't even gone this far; in some cases the expediter named obviously is not in sympathy with the commission's recommendations.

At the same time Kestnbaum and others are preparing the way for possible congressional interest in the suggestions that require new laws. At any rate, if Congress decides to act, Mr. Kestnbaum and his people will have all the facts well in hand.

Progress may be made next session on a few of the recommendations, such as the one calling for a reorganization, under better financing, of the Armed Forces Medical Library. It would be designated a National Medical Library. Both Democrats and Republicans on the Senate labor and welfare committee are interested in this project.

While that is not regarded as a controversial recommendation, many others are. The major changes proposed in the Veterans Administration's medical program couldn't conceivably be put into effect by Congress in the face of united opposition by servicemen's organizations. Yet, some daring senators and representatives are out on a limb already, having introduced bills to revamp V. A. along with other federal medical operations.

Here are some of the proposals being warmed over for Congress:

1. **Set up a Federal Advisory Council of Health,** to advise the President on all federal medical matters, including construction of hospitals and training of personnel.
2. **Eliminate free U.S. medical care** for merchant seamen and turn the job back to their employers; substitute contributory health insurance for the present haphazard but free system of U.S. care for military dependents and for Coast Guard, Public Health Service, and Coast and Geodetic Survey personnel and dependents.
3. **Immediately close down** certain specified V.A. hospitals, and strictly limit nonservice care, but still with the understanding that "a sick and really indigent veteran" is entitled to help.
4. **Make the V.A. nonservice case** liable for repayment of costs "for some reasonable time in the future."
5. **Regionalize all military hospitals,** with one of the services in charge of each region.
6. **Review and reappraise the Hill-Burton program,** with special attention to the validity of present bed-ration standards, the regionalization of hospital services, and the relation of the small community hospital to total hospital program; in other words, determining whether H-B hospitals are properly and efficiently fitted into the total national hospital picture.

Tracy Voorhees, who has been closely associated with federal hospital and medical programs, now is spending quite a bit of time with the Kestnbaum group attempting to stir up some action in Washington on these questions. He is enthusiastic but realistic. He knows that nothing will be accomplished in a hurry.

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Patients must be billed for the professional services of the pathologist and radiologist in the name of the physician. The hospital may act as the physician's collection agent, but in such cases the physician's name must appear on the hospital's statement.

Hospitals legally can charge patients for the use of facilities provided by the hospitals in the pathology and radiology departments. In this event, the physician would submit a separate bill to the patient for professional services.

The hospital legally can lease space, equipment and other facilities to the physician. This lease can provide for payment of a flat sum or a percentage of the departmental income, provided the payment is from the physician to the hospital.

Physicians may own the equipment in the pathology or radiology departments if they so prefer.

Laboratory technicians may be employes of either the hospital or the physician. Details of the status of these technicians, as well as details of financial arrangements between doctors and hospitals, are to be worked out at the local level.

Attorneys for the Iowa Hospital Association argued during the lengthy trial that nonprofit hospitals should be exempted from the legal rule against the corporate practice of medicine. Judge Moore, however, found that "most of the reasons given in the [cited legal] decisions condemning corporate practice generally are applicable to the nonprofit corporations." He added:

"The law applies to all and must not be violated even if the intention is only to do good." The Iowa Hospital Association attorneys also argued that there was "strong evidence" of the legality of present hospital-specialist relationships because of their lengthy history.

Judge Moore commented in his ruling that "the failure of those charged with the enforcement of the law cannot write an exclusion to the provisions of the law."

He added that the hospitals "are not entitled to operate pathology and x-ray laboratories merely because they have done so for many years, nor has the court the right to indulge in judicial legislation. The law is established and if there is a change it is for the legislature and not this court. If the nonprofit corporations operating hospitals are to practice medicine it is for the legislature to say by proper legislation."

The pathologist and radiologist who permits "a hospital to bill for medical services in the name of the hospital without the consent of the patient" is violating a state law prohibiting the secret division of medical fees, Judge Moore ruled. He also ruled that "the work done by the pathologist, radiologist and the technicians working in the pathology and x-ray laboratories constitutes the practice of medicine."

He added: "Under Iowa law the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation."

"Both the hospitals and physician specialists," Judge Moore concluded, "have been violating Iowa law."

The hospitals, his ruling said, "have been engaged in the unauthorized, unlicensed and illegal practice of medicine.

(Continued on Following Page)

"And the pathologists and radiologists have been violating the provisions of Iowa law prohibiting the secret division of professional fees."

At the end of his 32 page ruling, Judge Moore noted:

"It is the opinion of the court that the furnishing of proper pathology and x-ray services to the patients in the hospitals can be worked out on the local level and within the law."

He directed that the costs of the lengthy trial should be levied against the Iowa Hospital Association.

That association maintained during the trial that the work of pathologists and radiologists should be regarded as hospital services provided by the hospital to the medical staff.

The Iowa State Medical Society and other defendants in the lawsuit argued that the work of these physician-specialists constitutes medical service. The pathologists and radiologists, according to this view, are consultants of attending physicians and have an ethical obligation to bill patients directly for their services.

Judge Moore upheld this contention of the Iowa State Medical Society.

Defendants in the Iowa Hospital Association lawsuit filed last January included the Iowa attorney general's office, the Iowa State Board of Medical Examiners, and the Iowa Association of Pathologists. The Iowa State Medical Society entered the case as intervenor on the side of the defendants.

(FOR EARLIER STORY, SEE PAGE 72)

wire from Washington

HOOVER COMMISSION ACTION

Behind the scenes in Washington some pressure is being built up to get action on the Hoover Commission's recommendations, including many in the health and hospital fields. There is not much possibility that the Congress will be bowled over by the movement, but the promotion is being handled carefully and intelligently and it may meet with success here and there.

Heading it up is Meyer Kestnbaum, chairman (1953-54) of the Commission on Intergovernmental Relations, which did a scholarly job of appraising the relative rôles of the federal, state and local governments in activities in which all are involved, such as Hill-Burton and other grants.

Kestnbaum has the advantage of not working on the outside but of being attached to the White House as special adviser to the President. It is his job to induce federal officials and departments to put into effect those seemingly noncontroversial recommendations of the Hoover Commission that do not require action by Congress. Here the greatest obstacle is admittedly inertia, which is a problem in official Washington regardless of the party in power.

Part of the strategy is to prevail on each secretary and administrator to make one person in his department or agency responsible for following up on the recommendations. Some departments have these expediters already functioning; other agencies haven't even gone this far; in some cases the expediter named obviously is not in sympathy with the commission's recommendations.

At the same time Kestnbaum and others are preparing the way for possible congressional interest in the suggestions that require new laws. At any rate, if Congress decides to act, Mr. Kestnbaum and his people will have all the facts well in hand.

Progress may be made next session on a few of the recommendations, such as the one calling for a reorganization, under better financing, of the Armed Forces Medical Library. It would be designated a National Medical Library. Both Democrats and Republicans on the Senate labor and welfare committee are interested in this project.

While that is not regarded as a controversial recommendation, many others are. The major changes proposed in the Veterans Administration's medical program couldn't conceivably be put into effect by Congress in the face of united opposition by servicemen's organizations. Yet, some daring senators and representatives are out on a limb already, having introduced bills to revamp V. A. along with other federal medical operations.

Here are some of the proposals being warmed over for Congress:

1. Set up a Federal Advisory Council of Health, to advise the President on all federal medical matters, including construction of hospitals and training of personnel.

2. Eliminate free U.S. medical care for merchant seamen and turn the job back to their employers; substitute contributory health insurance for the present haphazard but free system of U.S. care for military dependents and for Coast Guard, Public Health Service, and Coast and Geodetic Survey personnel and dependents.

3. Immediately close down certain specified V.A. hospitals, and strictly limit nonservice care, but still with the understanding that "a sick and really indigent veteran" is entitled to help.

4. Make the V.A. nonservice case liable for repayment of costs "for some reasonable time in the future."

5. Regionalize all military hospitals, with one of the services in charge of each region.

6. Review and reappraise the Hill-Burton program, with special attention to the validity of present bed-ration standards, the regionalization of hospital services, and the relation of the small community hospital to total hospital program; in other words, determining whether H-B hospitals are properly and efficiently fitted into the total national hospital picture.

Tracy Voorhees, who has been closely associated with federal hospital and medical programs, now is spending quite a bit of time with the Kestnbaum group attempting to stir up some action in Washington on these questions. He is enthusiastic but realistic. He knows that nothing will be accomplished in a hurry.

The Modern Hospital
DECEMBER 1955



LOOKING AROUND

Tomahawk, Please!

SURGEONS and nurses at Brooklyn's Methodist Hospital were startled one morning not long ago, when the operating room schedule was posted, to see an unusual procedure listed: "Removal of 3/5 of scalp," this read. When the surgeon showed up for the posted operation, he was confronted by a curious throng of his colleagues who wanted to know what was going on.

The mystery was quickly cleared up, Administrator Vernon Stutzman reported, when it developed the operation had been scheduled by telephone, with a newly employed clerk on duty at the hospital. The surgery was routine: Removal of 3 cysts of scalp.

Hero's Journal

DOCTORS and hospital people are often annoyed, and sometimes enraged, by books and articles that are critical of their performance and, it is felt, result in public mistrust of the professions. Occasionally, such public criticism is justified, putting the spotlight on bad performance or, what is worse, bad intentions, and pointing the way to needed improvement or reform. More often than not, perhaps, the criticism results from misunderstanding of professional aims and standards, or from the tendency of the popular press to oversimplify and overdramatize — an unfortunate practice that often makes dunghills out of flyspecks.

If professional people are understandably disturbed when such unfavorable publicity appears, they should also be vastly comforted by the unending flow of reports describing their good works and leaving an impression of competence, skill and devotion to duty. Like a spring-fed lake, the public reservoir of good will toward medicine and hospitals is constantly renewed and refreshed by such reports. Thus, for example, hospitals everywhere gain something whenever, as happens every day in hundreds of cities and towns, the newspapers report that accident victims have been taken to the hospital for treatment. Thus all physicians gain a little in stature when one of the great circulation magazines reports a new technic in diagnosis or treatment, and when medical discoveries and triumphs are reported on such television programs as "March of Medicine," or dramatized — some say overdramatized — on "Medic." Thus doctors and hospitals generally share in the nation's gratitude for the prompt, effective medical and hospital care which have helped President Eisenhower recover from the heart attack that shocked the world.

Thus, most recently, physicians and hospitals will be honored by all who read an extraordinary book that has now been published in the United States—the diary of a hospital administrator who faced incredible disaster with a calm courage and sense of responsibility unsurpassed in medicine's long, shining history.* Doctor Michihiko Hachiya's Communications Hospital was less than a mile from the center of the atomic explosion that destroyed his city of Hiroshima and killed or maimed half a million people. Severely injured himself, and with only the shell of the hospital building left standing, Dr. Hachiya rallied his staff and personnel and, within a few hours, began the staggering task of caring for the dying and wounded who poured into the hospital seeking aid.

In simple, factual language, Dr. Hachiya tells the epic story of the next six weeks. Only physicians, hospital administrators and nurses, perhaps, can fully appreciate the appalling difficulties that had to be met, the dreadful decisions that were made, the shocking conditions encountered as the staff struggled not only to care for injured victims of the catastrophe but also to understand and cope with the mysterious and terrifying condition from which thousands who were outwardly unharmed were dying. Illustrative of the extraordinary singleness of purpose of these men and women is the fact that, within 30 days after the disaster, a professor from the University of Tokyo addressed a meeting of the Communications Hospital medical staff on radiation sickness, and Dr. Hachiya had written and published a paper on the subject to inform and reassure those who were still alive.

If doctors and hospital administrators alone can understand all the details, every sensitive reader will understand that here is a man who performed his heroic task with compassion for the suffering and without bitterness toward those who caused them to suffer. Everlastingly, all his readers will respect the medical profession more because of Dr. Hachiya.

*Hiroshima Diary, The Journal of a Japanese Physician, by Michihiko Hachiya, M.D. Translated and edited by Warner Wells, M.D. Chapel Hill: The University of North Carolina Press, 1955.

Surgeons Study Operating Room Infections

Growing resistance to antibiotics and poor housekeeping in operating rooms are creating wound infection hazards, speakers warn at American College of Surgeons Congress

CHICAGO.—**Hospital operating rooms are often unclean, with the result that the rate of surgical wound infection is higher than it should be, Dr. Carl W. Walter, assistant professor of surgery at Harvard University and a member of the surgical staff at the Peter Bent Brigham Hospital, Boston, said here last month at the 41st annual clinical congress of the American College of Surgeons.**

Speaking at a postgraduate course in preoperative and postoperative care, Dr. Walter said hospital maids and orderlies are not doing a thorough job of cleaning operating rooms today. Another factor in the increase in operative wound infections is the increasing resistance to antibiotics of many organisms, Dr. Walter said.

"Surgeons should take back the responsibility for keeping hospitals clean," Dr. Walter declared, adding that the responsibility had been taken over by laymen. "It is not the duty of surgeons to run a hospital, but they are obliged to demand that conditions shall be sterile for their patients. Hospitals have to get back to being clean, safe places."

Dr. Walter's statement was immediately challenged by Dr. Dwight E. Clark of Chicago, a member of the surgical staff at the University of Chicago and chairman of the public relations committee for the congress. Some hospitals may be guilty of the charge made by Dr. Walter, Dr. Clark said, but the great majority are kept scrupulously clean throughout and do an excellent job of safeguarding patients against infection, he insisted.

More than 10,000 physicians were registered for the congress and took part in discussions covering every phase of surgical care. Approximately 800 physicians participated in the program as authors of research papers, lecturers and discussion participants, according to a college announcement.

In another paper presented at the session on postoperative care, Lt. Col. Edwin J. Pulaski, an army surgeon stationed at Honolulu, warned against the practice of giving surgical patients antibiotics routinely following operations. In most cases the antibiotic isn't needed, Col. Pulaski said, and in some cases the practice may actually be dangerous, because the drug may kill or inhibit harmless bacteria, thus upsetting the natural balance of pathogenic and "innocent" organisms.

Routine administration of antibiotics to surgical patients has also increased the number of patients and organisms with resistance to antibiotic agents, Col. Pulaski stated.

In a third report on operating room infections, Dr. Jerome J. Landy of the Veterans Administration Hospital, North Little Rock, Ark., presented the results of two studies conducted in the department of surgery at the University of Chicago in 1952 and 1955. Nose and throat cultures from staff members of the department showed marked changes in 1955, compared to 1952, Dr. Landy reported, with fewer Staphylococcus infections showing up in the later period, which also showed an increase in the number of gram negative enteric organisms.

The studies showed a relationship between infections carried by staff members and those developing in surgical wounds, it was reported. In the 1955 study, for example, enteric organisms were found in 16 per cent of the staff members, it was reported, and this type of organism caused 44 per cent of the wound infections.

MASS CASUALTIES

A comprehensive program to prepare U.S. hospitals and communities for the medical management of mass casualties was recommended by Dr. Frank B. Berry, assistant secretary of defense (health and medical), who presented the annual trauma oration at the congress. Dr. Berry outlined six essential points of the medical preparedness program, including cooperation by doctors and hospitals with civil defense authorities in the organization of medical personnel by cities and by regions.

Other phases of the program outlined by Dr. Berry were:

1. Accumulation and storage of medical supplies.
2. Universal immunization against tetanus.
3. Universal blood typing and marking.
4. Emphasis on principles of traumatic surgery in surgical teaching.

Explaining the need for blood typing and marking, Dr. Berry said: "It is no good to provide people with tags or cards, as these are frequently missing. The surest method is tattooing of the blood type on every individual.

"This can be done at the waistline, an area usually protected by the belt, or in the lower axilla, another protected site. This may sound radical, but it is the simplest and only sure method of making available what may prove to be lifesaving information."

The importance of medical planning in advance of disaster has been demonstrated repeatedly in U.S. disaster ex-

perience, from the San Francisco earthquake to this year's New England floods, Dr. Berry stated.

"Two years ago, a section of the city of Worcester, Mass., was devastated by an unexpected tornado," he related. "The medical record was not good. Some hospitals were jammed while others stood half empty, awaiting patients.

"In the confusion that followed, entrances and exists became blocked with traffic, and hospitals were overloaded and failed to send patients on to less crowded institutions. In addition to the patients, relatives and friends milling about in the wards and corridors added to the confusion.

"Surgeons who had been in the war forgot their training and hurriedly sutured wounds without proper debridement—this within a decade of our recent experiences in World War II and Korea, and the mass of wound literature that has been constantly available."

In time of major disaster, such as enemy bombing of American cities in wartime, every able-bodied citizen automatically becomes a member of the medical emergency organization, Dr. Berry emphasized.

"A disaster producing 100,000 casualties in a single city propounds an enormous problem, but what if many cities are damaged at the same time and the casualties are hundreds of thousands?" he asked. "What happens to our present elaborate medical organization, geared to the intricacies and details of care in fine institutions where personnel and time are plentiful?"

MEDICAL SUPPLIES

"In major disasters, we have the reverse. These institutions may no longer exist or may be damaged so that they have no light, heat, water or food. Now personnel and time are scant and of the utmost urgency. How do we handle the sick and wounded with almost nonexistent or limited, makeshift facilities?

"There must be a sound plan for sorting, rapid evacuation and dispersion. Every means available for evacuation will be employed. As a plane brings in medical supplies, that plane will probably be used to evacuate casualties, and roads, rail and water must also be utilized to the greatest extent possible."

Proper collection and storage of medical supplies are also important in preparation for disaster, Dr. Berry indicated. "Again in the confusion of the Worcester disaster, none of the 1120 units of blood which were drawn locally in the first 24 hours could be used because of lack of refrigeration, lack of sterility, and lack of materials for proper typing," he reported.

"Many makeshifts and improvisations will have to be made both as to hospitals, the utilization of medical and paramedical personnel, and treatment afforded. All doctors will have to consider themselves as doctors and forget in large measure that they are specialists.

"From the great disasters of the past, we have learned the absolute necessity for proper organization and direction. Without such organization, panic will ensue. This panic may be likened to the stampede of horses and cattle in a burning stable when, by milling about, they eventually destroy themselves rather than accept the way to safety. So with the ill conceived and almost thoughtless actions of people at such times, prompt and vigorous leadership may prevent or quell such panic. All of our cities and towns, even our smallest communities, should be ready with a plan of action which includes assistance to their neighbors."



Left to right: Dr. Paul R. Hawley, director of American College of Surgeons; Dr. I. S. Ravdin, chairman of board of regents, and Dr. Alfred Blalock, retiring president, at regents' meeting during congress. Following meeting, Dr. Ravdin announced that a committee of regents of the college would undertake a study of surgical fees aimed at determining the extent to which exorbitant fees cause poor doctor-patient relations.

STUDY SURGEONS' FEES

During the congress, Dr. I. S. Ravdin, chairman of the board of regents of the American College of Surgeons, announced the appointment of a special committee of regents to study the problem of exorbitant surgical fees.

The announcement was made at a press conference at which Dr. Ravdin told reporters that the college intends to "maintain vigilance to see that the public interest is protected as far as fellows of the American College of Surgeons are concerned."

The committee is a fact-finding body that will report back to the regents at the next meeting of the board, Dr. Ravdin explained, and any subsequent action by the college will depend on findings of the study.

Dr. Ravdin said the regents were convinced the problem should be studied because of recent statements indicating that high fees were one cause of deteriorating relations between patients and physicians.

"We do not intend to police American medicine," Dr. Ravdin stated, "but it is the function of the regents to see that fellows of the American College of Surgeons do not engage in practices we consider contrary to the best interests of surgical patients."

Dr. Ravdin emphasized the committee would not seek to establish standardized fees. Rather, he said, the committee would try to determine whether or not exorbitant fees are a factor in poor patient-physician relationships. "The Truman Report (of the American Medical Association) and other evidence indicate high fees are tied up with the problem of fee splitting," he declared. "We are seeking the facts."

The college campaign against fee splitting in the last three years had not eliminated this practice, Dr. Ravdin acknowledged. "But," he added, "we have made a healthy dent in the practice."

Dr. Ravdin also explained to the conference how the Joint Commission on Accreditation of Hospitals has operated to eliminate unjustified surgery and improve patient care in accredited hos-

(*Continued on Page* 166)

We Need New Patterns of Nursing Care

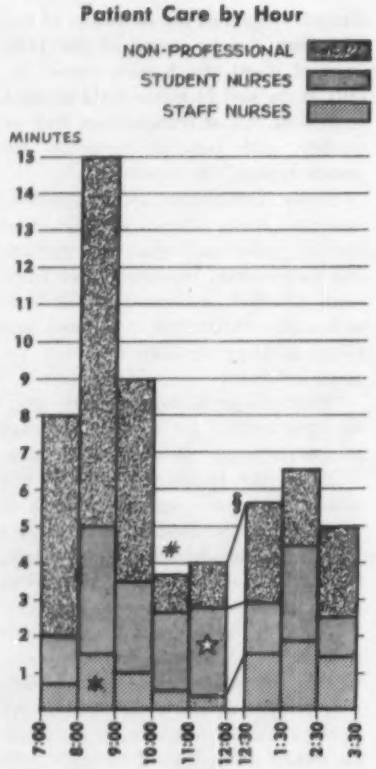
Time study reveals the factors that keep nurses away from the patient's bedside and suggests ways of getting them back there before the patients forget what an R.N. looks like

EVERETT A. JOHNSON and EDWARD NELSON

SINCE the early part of World War II general hospitals have been faced with conditions far different from those that obtained in "the good old days" when only the selected few of the graduating student nurses were invited to accept staff nurse positions upon graduation. Certainly hospitals are aware of tremendous adjustments in the last 15 years in their staffing patterns, but what of these changes as seen by the patient?

Typically, the patient enters the hospital confidently expecting that during his stay he will be cared for by professional nurses. Unless he is too sick to care, however, he is in for a shock: Where is the familiar figure in the white uniform? He is bewildered by a succession of blue, gray and striped uniforms. On any given day from 7 a.m. to 3:30 p.m. he will probably see a professional graduate nurse *less than five minutes*. He will probably see professional personnel, including students, less than 10 minutes. During his entire stay he will average on this shift 54 minutes of direct bedside care, which will be divided as follows: 6 minutes given by graduate nurses, 14 minutes given by professional students, and 34 minutes given by nonprofessional personnel.

Are the nurses avoiding him? To answer this, let us look at what the patient does not see, *i.e.* staffing patterns, how nurses and other personnel spend their time, and how traditional work methods affect the care the patient receives. By studying the problem from the point of view of the patient and also from the standpoint of nursing administration, we can determine implications for future patterns of nursing care.



Graph 1: Number of minutes of care per patient given by nonprofessionals, students and staff nurses. Symbols mean: *Time spent entirely with one colostomy patient; ★ 85 per cent of time spent with one postoperative patient; # coffee break, and § lunch.

What is the situation from the patient's point of view? A time study of three groups of patients produced the following results.

On three days a group of seven or eight patients was selected and all the care the patients received during the day shift was recorded, except for a 30 minute lunch period. The patients selected were close to each other, but otherwise the patients and days of observation were picked at random.

Of the 23 patients in the study, 15 received less than 5 minutes of care by graduate professional nurses, 20 received less than 10 minutes of care by graduate professional nurses, 13 received less than 10 minutes of care by all professional personnel, as shown in Table 1.

On the day shift for the nursing units studied, the amount of nursing care assigned to the patients reported was approximately 3 hours, as shown on Graph 1.

A serious problem is illustrated by this graph. It shows the average number of minutes of direct bedside care which the patient receives at each hour of the day shift. Notice how precipitous is the slope from the frenzied heights of a.m. care to the leisurely valley of the coffee break and the charting desk. From the standpoints

Table 1—Amount of Care Rendered by Various Types of Nursing Personnel

	Professional Nurse	*Student Nurse*	*Nonprofessional*	*Total*
Average number of minutes of care per patient	6 min.	14 min.	34 min.	54 min.
Per cent of total care	11	26	63	100

Mr. Johnson is the administrator and Mr. Nelson is administrative assistant, Methodist Hospital, Gary, Ind.

of either patient care or utilization of time there is no reason for so much activity with the patients between 8 and 9 a.m. and so little between 10 and 11 a.m.

In the graph and this discussion are condensed a mass of statistics recording the number and type of visits of all personnel, diseases of patients, sex, ambulatory status, number of days of hospitalization, and ages of patients. Many comparisons and correlations among these items were made, but no significant results were found. For example, the ambulatory patients received as much professional and nonprofessional attention as the bed patients did.

For a second point of view of activities on nursing units Graph 2 charts the activities of typical workers in three jobs by major areas of work. A study of this material indicates how nursing service employes are spending their time.

The material on which the graphs are based is the result of a study of six months on several of the nursing units within the hospital. In addition to the facts presented, much additional information has been reported, conclusions have been reached, and further questions have been raised. These data can be summarized by the following generalizations.

It was found that on the average a nursing unit had fewer than three graduates to cover the entire 24 hours, if the head nurse was not counted. Often there was no graduate on the day shift other than the nurse in charge.

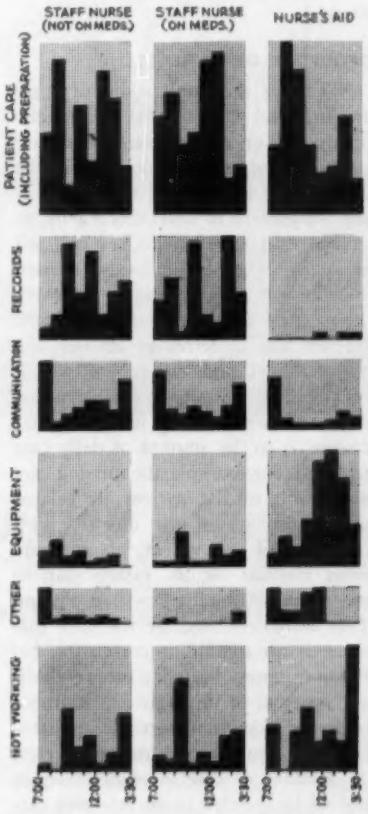
During the period studied some nursing units averaged almost four private duty nurses on most shifts. It is odd that hospitals have so little control over them. It is as if General Electric, despite the shortage of engineers, allowed its clients to hire engineers privately—at a higher salary than G.E. pays—and let them use G.E. equipment and facilities.

The personnel that worked on the nursing units was scheduled quite irregularly. On some days it happened that the number of people giving patient care was double what it had been on the previous day. The schedules of professional students and practical nurse students had to be integrated with the schedules of regular employes. This was done by the head nurse, in an atmosphere of constant interruption and pressure by the employes seeking to arrange their days off in complicated patterns. The part-time employes, in particular, virtually scheduled themselves. With all these factors—many of them beyond her control—to coordinate, it is no wonder that the head nurse may have too few people one day and too many the next.

This irregularity affected the patients mainly on the afternoon and night shifts. Sometimes lights went unanswered for a long time; on other nights there was no problem. The difficulty here is lack of mobility in the nursing force. At night when one unit was busier than usual if anyone was sent to answer a light it was probably an aide, often unqualified to help where help was needed. Nurses who worked on a floating basis were often dissatisfied with the arrangement. They were frequently put in charge of units in which they were unfamiliar with both the patients and the special problems of the area; they were shifted around too frequently during one shift, or their time was squandered on unskilled work. And yet there was a need for floating nurses to care for a few acutely ill patients during the afternoon and night shifts.

Sometimes the shortage of R.N.'s was so acute that a practical nurse was put in charge of a unit. This meant that she had to do many things for which she was not trained. Aides also undertook skilled tasks at times because of the shortage of nurses. On all shifts the nonprofessional personnel worked with little supervision. It is no longer completely true that the patient's total nursing care is in the hands of professional personnel, with nonprofessional employes merely implementing portions of it.

Nursing Personnel Activities by Hour



Graph 2 shows the activities of typical workers in three jobs by major areas of work. A study of this material indicates how nursing service employes are spending their time.

Table 2 shows how the staff nurse spent her time on all shifts. "Patient care" includes preparation of medicines and treatments as well as actual bedside care. The figures are the average number of hours spent on the given area of activity.

This table indicates what is without doubt the biggest single problem in hospital nursing: Nurses are spending about 60 per cent as much time on records as they are on patient care.

The corresponding figures for the head nurse are: patient care, 1¼ hours; records, 1¾ hours; communication, 3¼ hours; other, 1 hour. Although some of the time spent on patient care utilized the head nurse's special abilities, the figures indicate that the lack of staff nurses was forcing the head nurse to spend too much of her time on routine nursing procedures. This routine work plus the 1¾ hours spent on records often kept the head nurse too busy to devote much time to planning for her patients and her unit and for supervising other personnel.

How much secretarial assistance does the head nurse have? The ward clerk spends her time on the average as follows: records, 2¼ hours; equipment, 2¼ hours; other, 1¾ hours.

Table 2—How the Staff Nurse Spent Her Time

	Patient Care	*Records*	*Communication*	*Other*
Nurse (day)	3¼	1½	1½	¾
Nurse (day, on meds.)	3¾	1¾	1¼	½
Charge nurse (p.m.)	2	1¾	2¼	¾
Charge nurse (night)	3	2¼	1	½

Obtaining equipment is as much a part of her job as is work with records. However, she had time left over. Yet most nurses hang on jealously to the routine clerical jobs, such as charting T.P.R.'s, ordering medicines, checking charts for orders which may have been missed, and so on. Perhaps a large part of the reason is fear of errors. This is not too surprising when it is realized that the ward clerks are hired with little or no training to do a vaguely defined job.

On the day shift aides spent their time as follows: patient care, 3¼ hours; equipment, 2 hours; other, ¾ hour. The aide's job, like the nurse's, is primarily to render patient care.

Time spent by nurses on records was devoted largely to patients' charts. This work is of five different types:

1. Routine charting. "Usual a.m. care given, diet taken, slept fairly well, sitting up, visiting, and so on." The routine phrases were written by hand on each chart; there was no check list for the necessary information.

2. Charting of medications and treatments. The name of the medication or treatment had to be written each time it was given. Also, there was no quick way of determining when all the doctors' orders had been carried out because the information was scattered throughout the chart.

3. Recording significant observations about the patient's condition. Not enough of this was accomplished. If a nurse was busy she felt she must get the routine charting done but sometimes neglected the observations.

4. T.P.R.'s. Taking T.P.R.'s twice daily on all patients consumed a great deal of time.

5. Headings and miscellaneous. Most of this information could have been recorded by the ward clerk or an aide at night.

Another traditional work method was instrumental in keeping the nurse away from the patient. This was the general practice of having one nurse assigned solely to giving medications and possibly, in addition, a student assigned to treatments. This meant that much less professional time was available to the patients for their general nursing care. Some nursing units are so designed that it would be difficult to divide these tasks among all the nurses. Still it should have been possible to make some of the medication nurse's time available for general nursing care. The difficulty was that the schedule was so arranged that she was busy on medications from 7:30 a.m. until around 1:30 p.m., and was free in a relatively slack period. If the entire medication schedule could be shifted two hours, *i.e.* starting at 9:30 a.m., it would be almost like having an extra nurse available for the morning care.

This is only one example of the results of specialization by professional nurses. Each time a nurse is given a specialized function it removes her from general nursing care. Suggested specializations must be viewed in this light. If a task can be done satisfactorily by trained nonprofessional personnel it would be all to the good to specialize that function. If it must be performed by professional nurses, however, specialization would mean that a little bit more of the general nursing care of the patient passes into nonprofessional hands.

GROUPING OF PATIENTS

What are the implications of these findings and conclusions? From the standpoint of patient care there are several. The most important is the grouping of patients on nursing units and assignment to units. Ordinarily, in general hospitals patients are grouped primarily by types of disease. When this method of grouping is followed, the nursing care needs of the patient are not met in terms of efficient use of personnel and equipment within the nursing unit. Our study showed no correlation for any one particular disease as to the amount of daily care required. For example, the nursing care needs of a cardiac patient are related to the severity of the disease, prior condition of the patient, his age, and other medical factors, rather than to the needs of another cardiac patient. This is underscored by the fact that there is no significant correlation between minutes of nursing care rendered and whether or not a patient is ambulatory or nonambulatory. It appeared that if a patient required more than 45 minutes of care in eight hours he should be handled in an intensive care unit in which there would be a small number of beds and a high ratio of professional nurses.

Because more than 60 per cent of the nursing service available is used in activities other than direct patient care, this work must be limited as much as possible. The more it can be reduced, the more feasible it is to continue raising nursing salaries. Continuing emphasis should be placed on the changes that have been discussed by hospitals for the last several years, such as good physical layout that eliminates walking time within the nursing unit, increased use of labor saving devices, and bringing as much service and equipment as possible to the unit.

Another area of importance in reducing time away from patient care is that of paper work required of nurses. This activity is the most time consuming activity of nursing. For medication nurses it was noted that for every 2 minutes of preparation and administration of medications, approximately 1 minute of charting was done. A review of nurses' notes revealed that many well worn clichés were used so frequently they lost meaning. This suggests that charting should be done by means of a check list and by exception; that is, only conditions and activities of the patients which are out of the ordinary routine should be written into nursing notes.

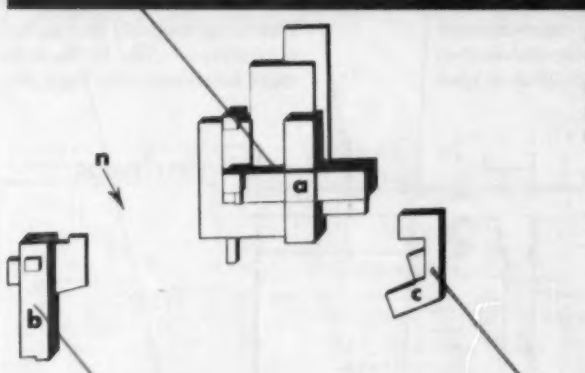
In our observations of all phases of nursing activities it appeared that the fundamental guidepost for nursing administration at all nursing levels was preparation for the ultimate activities that might occur. This feeling was particularly apparent on evening and night shifts. Such an attitude is understandable, but seems analogous to seeing the trees and missing the forest. In terms of total requirements for the nursing service it would be more efficient to establish a pool of nurses on each shift whose primary function would be to meet excessive patient care requirements throughout the hospital wherever they occur. The important point here is that instead of feeling responsible only for one particular task or individual nursing unit the nurses' attitude and orientation should be those of firemen—ready for action wherever they are needed.

Another implication of this study is that the recording of nursing hours per day is only a very rough guide as to the direct patient care rendered. Also it does not indicate the actual care needs of patients on any given day. It would be most helpful if an administrative index of this need could be developed.

A second broad area where changes appear to be in order is that of organization. In terms of salaries it means that nurses should be well paid for skilled work, but only when their skills are used to the maximum. The traditional education and work patterns on nursing units are not appropriate to

(*Continued on Page* 144)





Above: Facade of the Ochsner Foundation Hospital, New Orleans (see also this month's cover photograph). Left is a diagram showing the grouping of the main hospital (a) with (below, left) Brent House (b) used by guests and convalescents, and (right) Libby-Dufour nurses' residence (c).

THE MODERN HOSPITAL OF THE MONTH

Brent House



Libby-Dufour Residence



Efficient Planning Starts at the Top

Ochsner Hospital makes the most of nursing service

E. ALLEN DAVIS

THE new Ochsner Foundation Hospital in New Orleans is, categorically, a modern, intensely specialized, 250 bed hospital representing an investment approximating $5,500,000.

The new hospital was literally designed from the top down with four primary design considerations: a patient floor plan affording the most efficient possible usage of the nurses' time; preparation and provision for intended expansion to 500 beds; allocation and efficient placement of sufficient area for outsize surgery, recovery and laboratory-research facilities, and the over-all concept of "vertical planning" with efficient utilization of elevators, dumb-waiters, pneumatic tubes, card drops and so forth.

The architects, Ellerbe & Co., St. Paul, had, over a period of years, conducted an extensive study of various patient floor arrangements and concurrent nursing efficiency. From this study came the "cross plan" from a central nurses' station which would, in reducing the average distance to any patient, or number of patients, consequently increase nursing efficiency in direct, inverse ratio to diminishing "floor travel time."

A major factor in the success of this plan was a departure from convention in the decision to place the elevators at the end of one wing of the cross, and not at the center. The advantage of this plan was twofold: (1) It saved the space otherwise required for elevators at the vortex, thus affording a considerable condensing of the patient wings toward the nurses' center, and

(*Continued on Page 60*)

Mr. Davis is director of public relations of the Alton Ochsner Medical Foundation, New Orleans.



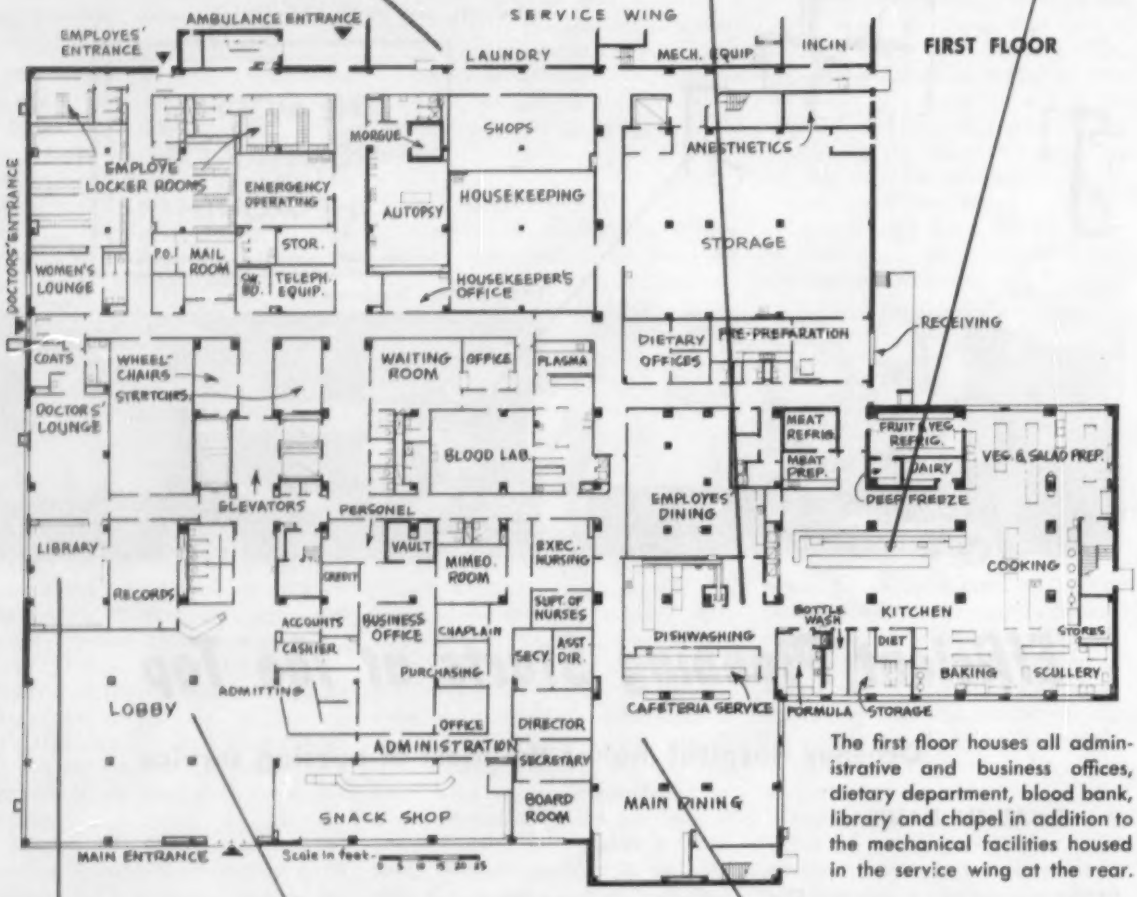
The laundry can wash, iron, fold and return linen to patient floors in 50 minutes.



Trays are lowered onto conveyor from which they go into dishwasher. Silver washer and sterilizer at rear.



Tray setup assembly line, moving by conveyor series to the automatic dumb-waiters at right rear.



The first floor houses all administrative and business offices, dietary department, blood bank, library and chapel in addition to the mechanical facilities housed in the service wing at the rear.



Reading room of the Ochsner Foundation Library adjoins the doctors' lounge.



The main lobby of the hospital. To the left of it is a snack shop and beyond are administrative offices.



Main staff and personnel dining room. Beyond are dishwashing area and employes' dining room.



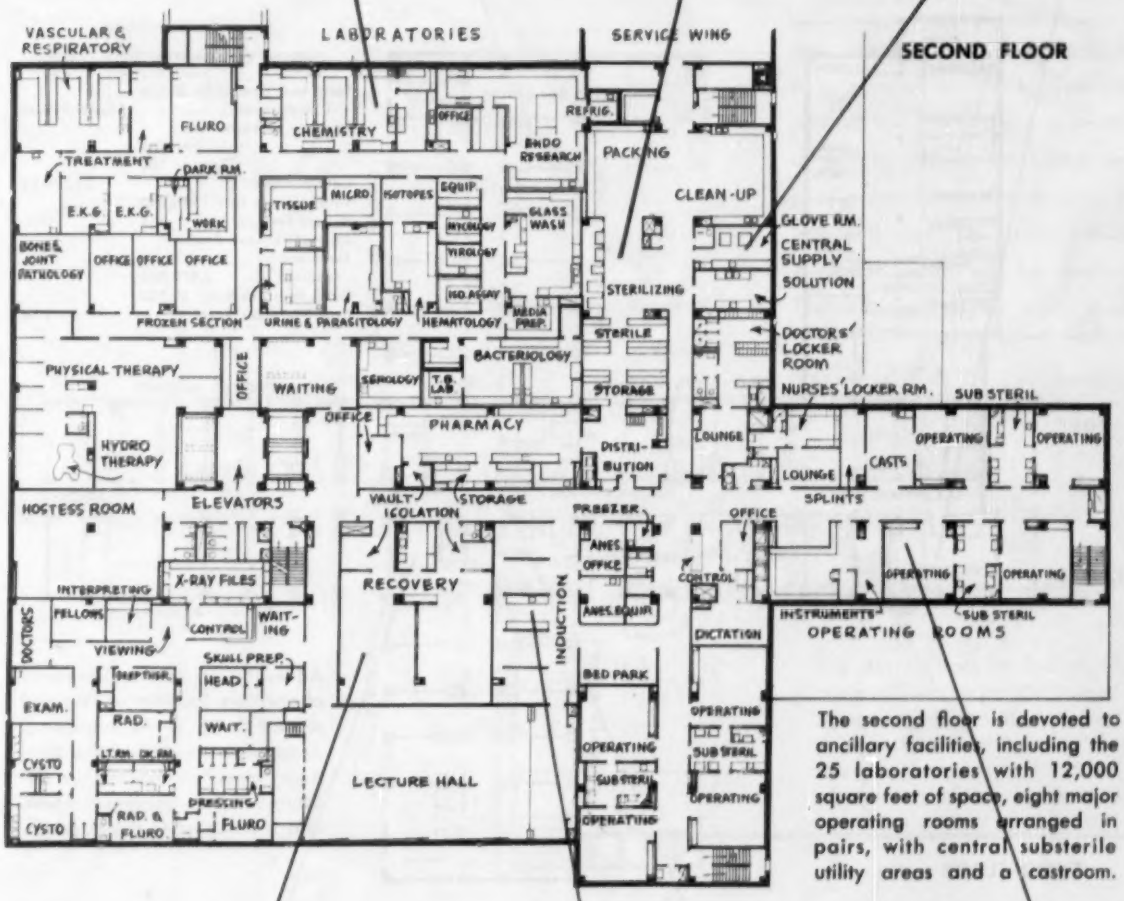
A section of the chemistry laboratory, one of the 25 laboratory units housed on the second floor.



An employe prepares load of supplies for the sterilizer in the central sterile supply department.



Heavy surgical load made necessary this special unit for handling rubber gloves.



The second floor is devoted to ancillary facilities, including the 25 laboratories with 12,000 square feet of space, eight major operating rooms arranged in pairs, with central substerile utility areas and a castroom.



Partial view of the hospital's postoperative recovery division, which has a capacity of 18 beds.



Part of the central anesthesia induction area located between recovery and anesthesiology office.



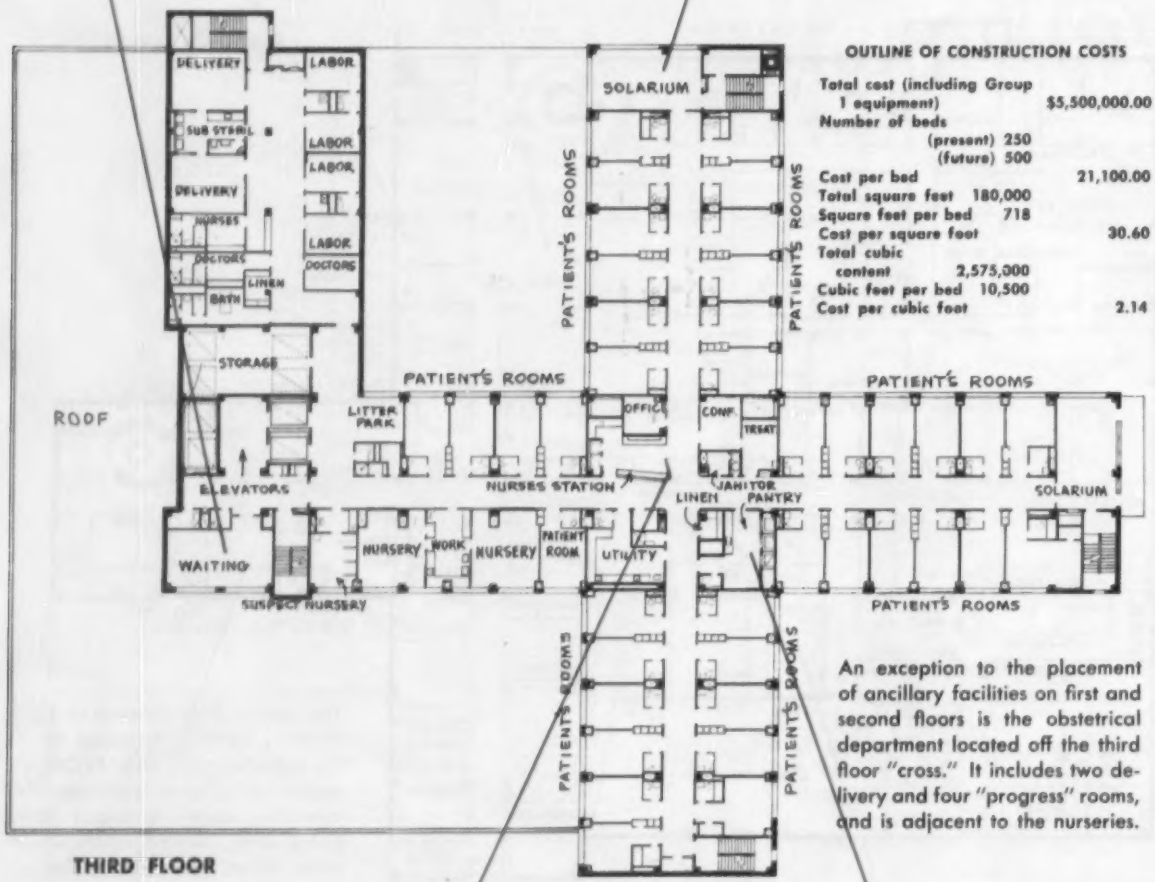
One of the eight major operating rooms, connected by utility, scrubup rooms.



Typical floor waiting room adjoining elevator lobby. Area includes restrooms and telephones for visitors.



Solarium on fifth floor, west. The hospital has six of these, each with balcony overlooking the Mississippi.



THIRD FLOOR

OUTLINE OF CONSTRUCTION COSTS

Total cost (including Group 1 equipment)		$5,500,000.00
Number of beds		
	(present) 250	
	(future) 500	
Cost per bed		21,100.00
Total square feet	180,000	
Square feet per bed	718	
Cost per square foot		30.60
Total cubic content	2,575,000	
Cubic feet per bed	10,500	
Cost per cubic foot		2.14

An exception to the placement of ancillary facilities on first and second floors is the obstetrical department located off the third floor "cross." It includes two delivery and four "progress" rooms, and is adjacent to the nurseries.

Typical patient floor nurses' control center, in the cross unit, equidistant from all patient rooms on floor.



Food dumb-waiters connecting with conveyor assembly in kitchen terminate in the patient floor pantries.



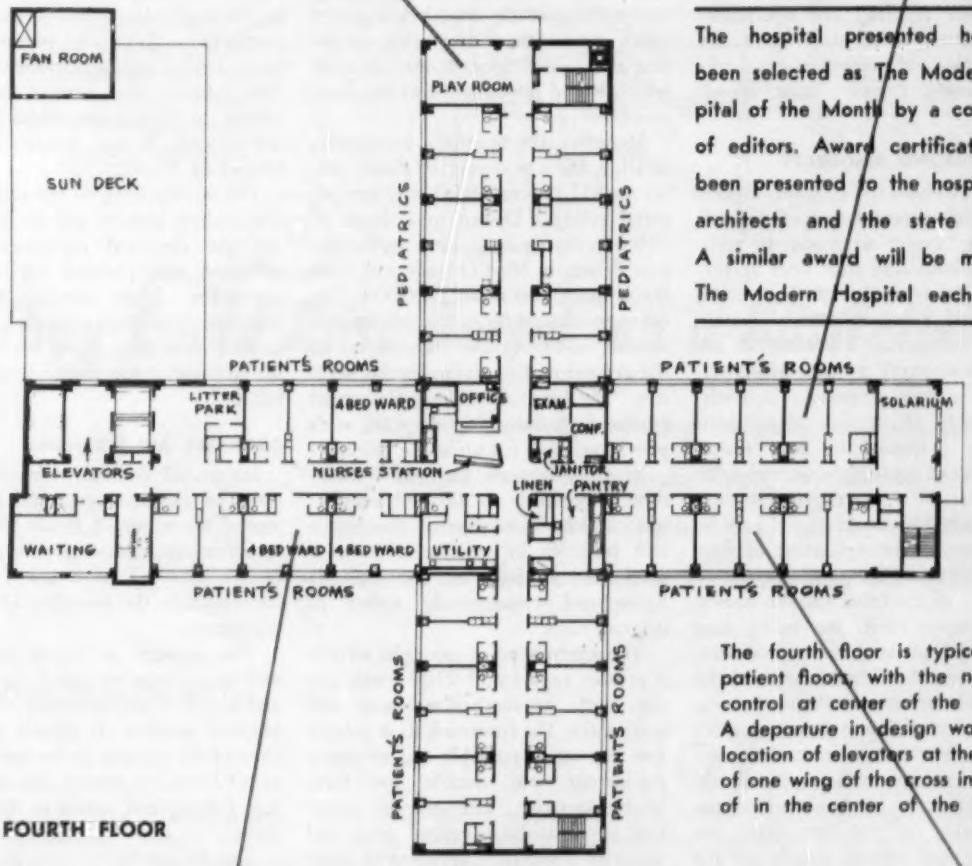


Pediatrics patients have their own special solarium playroom in the south wing overlooking the river.



Typical single room with bath. All patient rooms have toilet and lavatory; all private rooms have full bath.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



FOURTH FLOOR

The fourth floor is typical of patient floors, with the nurses' control at center of the cross. A departure in design was the location of elevators at the end of one wing of the cross instead of in the center of the floor.

Typical four-bed unit. Except for pediatrics division, the six 4 bed units constitute Ochsner's ward facilities.



A typical semiprivate room. The hospital has 94 double rooms, which may be converted to single rooms.



(*Continued From Page* 55)

(2) it permitted visitors to enter the floor at a place removed from the center of patient and nurse activity.

Subsequent to the "cross plan" decision was a second consideration—the determination of a maximum efficient usage in terms of patient beds served by this single nurses' center.

Various surveys and a comprehensive study of this question indicated that the figure would logically fall at about 90 to 95 beds per unit, remarkably high in terms of accepted standards. The determination was predicated primarily on the desired peak usability of requisite facilities and equipment at the nurses' center and, again, the consideration of approximate limits in increasing nurses' "floor travel" efficiency.

POOLS NURSING RESOURCES

The advantages and economy aspects of this high concentration of patients per nurses' center are many. In addition to minimizing the "floor travel" factor, a more efficient and generally higher level of nursing care is possible through an increased pooling of resources and nurse power. Moreover, it allows a more economical and efficient usage of nursing department secondary personnel in floor teams, with superior nursing supervision to each unit, and a better primary nursing balance throughout.

The nurses' center consists of four component areas, forming a square at the center of the cross, *i.e.*, the nurses' control center itself; the utility area with its well planned storage and service facilities; the dietary unit, and the combination treatment-conference area.

Vertical planning is nowhere more apparent than in the nurses' control area. As a station on the supply dumbwaiter series, it is connected to the blood bank on the first floor, the pharmacy and central supply on the second, and, of course, to the other nurses' centers. In addition, a card drop, primarily for supply and drug requisitions, provides a direct connection to the distribution center adjoining the pharmacy and central supply.

The distribution area, in addition, is the operating center for the hospital's dual systems of pneumatic tubes —in two sizes, for the handling of full medical records, and the customary smaller material, to and from 14 terminals on the first and second floors.

The hospital divides generally, and rather distinctly, into (1) patient areas, and (2) ancillary facilities and other areas. The placement of virtually all ancillary services on the first two floors has several advantages, but particularly facilitates a bilateral plan for expansion: vertically, by simply adding cross plan units for increased patient area, and, horizontally, for the first and second floors to afford expansion, if necessary, for other facilities.

In planning for the intended expansion to 500 beds through the addition of three patient floors, it was necessary to broaden considerably the ancillary base. In addition, soil conditions in New Orleans make it impractical to have usable areas below grade; hence the necessity of placing on the first and second floors numerous areas which would normally be in the basement.

Moreover, the hospital's foundation, to allow for a potential 10 floors, was set on 817 concrete-filled, end-bearing metal pilings. Driven to a depth of 120 feet, these pilings were the longest ever driven in New Orleans and, with the capping, cost about $500,000. The other provisions for expansion are extensive, including the termination in the present roof of all connecting services. The hospital is presently served by two fully automatic elevators, with provision made for up to six more.

In many respects, Ochsner Foundation is presently a 500 bed hospital with 250 beds, as original equipment and facilities in various areas were predicated initially on the ultimate figure and, consequently, reflect in original costs.

The kitchen, as an example, affords a present capacity of 2100 meals per day, with its mechanized plan and equipment. The future addition only of one tray series assembly and accessory equipment will double the serviceable capacity. This original provision of normally oversized areas and facilities is similarly apparent in other sections, particularly throughout the second floor in surgery, recovery, the laboratories, and so on.

The placement of all ancillary facilities on the first and second floors makes possible the efficient stacking of uniform patient floors while maintaining the vertical transport connection with important service and supply areas. In addition, this arrangement allows the planning of a generally non-public floor, the second in this case, and the placement there of central supply, surgery, recovery, x-ray and laboratories.

The hospital is equipped throughout with year-round air conditioning, and additionally affords individual thermostatic control for each room and area. A secondary control system provides variable humidity by areas, which is of particular importance in surgery, recovery and the nurseries.

The versatility and capacity of this air conditioning system made possible a windowless second floor as desired, which in turn facilitated the inclusion of special insulation for its high humidity areas.

The hospital's first floor includes the lobby, adjoining coffee shop, administrative and business offices, dietary department and dining rooms, blood bank, doctors' lounge, Ochsner Foundation Library, and various other facilities. A focal point, which is much appreciated, is the hospital's lovely Chapel of Prayer.

The service wing to the rear houses the modern laundry and the mechanical and electrical equipment, with sufficient area planned for intended expansion. Three separate electrical systems, including a diesel-operated standby generator, equip the building for any emergency arising from power failure.

CATWALKS AID SERVICING

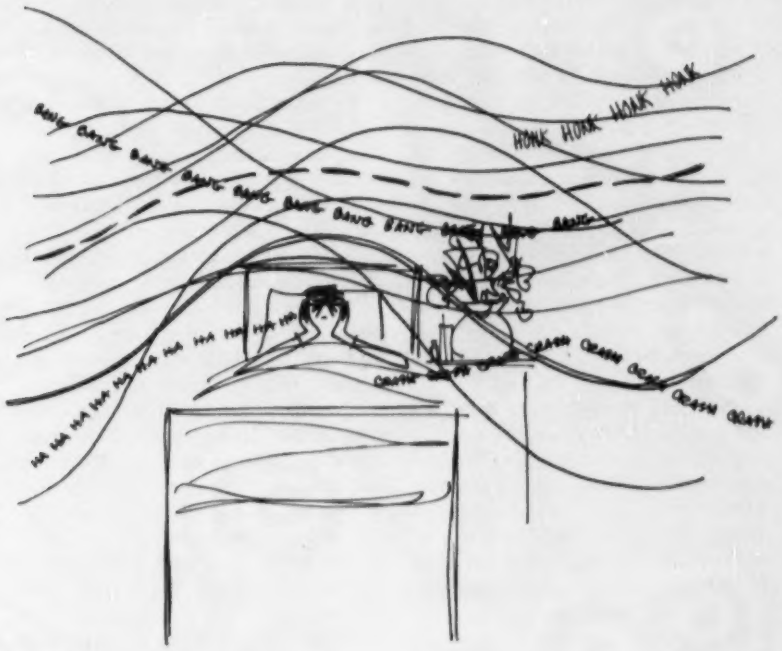
Suspended ceilings, with nearly 2 miles of catwalks, over the first and second floors, afford almost unlimited modifications, additions of services or equipment, and of course, facilitate tremendously the servicing of present equipment.

The laundry is largely automatic and extensively equipped for present and future needs, including other than hospital services. It affords a design time of 50 minutes in the handling of soiled linen, for receipt, laundry, ironing, folding and return to the patient floor.

The dietary department, in addition to patient service, operates two dining rooms adjoining its first floor area. All of the dietary areas, including the kitchen, are air conditioned. The patient tray assembly utilizes a well planned conveyor series passing through the service setup area, checking station, and into the three automatic dumbwaiters, terminating in the dietary areas of the nurses' center on each patient floor.

The efficiency of this system is augmented by a special intercommunication system to control and correlate

(*Continued on Page* 146)



Noises to right of them, noises to left of them volley and thunder. If patients go crazy, it's really no wonder.

They Could Rest Better on a Battlefield

Giggling females, bouncing bedpans, and squeaking hinges combine to make "rest" a delusion and a snare in most hospitals, but they can be muffled if the administration cares enough to do something about them

JOHN FRENCH ALLEN

THE complaints of patients, properly solicited and carefully studied, are undeniably an excellent index to the condition of a hospital. But for a real inside look and quick corrective action there's nothing nearly so effective as a sick administrator.

If that sounds like a rather drastic means of diagnosing the ailments of a hospital, hear the story of San Francisco's St. Francis Hospital, of Administrator Orville N. Booth, and of a whole lot of noise.

St. Francis is a topflight hospital, widely known for its good public relations, its excellent surgical staff, and its employe-patient rapport (the story of the St. Francis employe conference was told in these pages). A major method Mr. Booth uses to keep his staff abreast of patient needs and patient discontent is a well written and cleverly illustrated questionnaire. A copy is sent to the home of each patient as soon as his hospital stay is over.

Mostly these days the answers are on the bright side, the comments tend to be highly complimentary, a state of affairs bound to swell the chest—if not the head—of any administrator.

But the answers, Administrator Booth noted, fell short of bringing complete complacency: On far too many of the returned questionnaires there was one big complaint—too much noise in and around the hospital. In one series of 372 returned questionnaires, for instance, 58 patients mentioned noises of various sorts as their only cause for complaint. Singly, the complaints seemed unimportant. Taken together they made St. Francis sound like a boiler factory.

There were bedpans rattling all night long; someone was practicing jungle drum rhythms on a laundry chute door; flushing toilets roared like express trains; student nurses giggled endlessly and sometimes hurled imprecations at each other; delivery men regularly played tiddlywinks at dawn with manhole covers in the alley.

Mr. Allen is the science editor of the San Francisco Examiner.

Exaggerations? Sure. But then the ears of the ill are unusually sensitive. So Mr. Booth set his staff to investigating the sources of all the noise. Employes were asked to cooperate; delivery people and outside service companies were warned. Through the San Francisco Hospital Conference the local press was asked to help keep the public as quiet as possible outside the hospital. In this respect St. Francis is particularly vulnerable, since it is situated at the intersection of two one-way arteries which carry heavy loads of autos in and out of downtown San Francisco.

The press was happy to help, but one newspaper, the *Examiner,* couldn't help adding its own bit of telling advice to the hospitals. In an editorial, which carried a bit of gall under its alleged humor, the *Examiner* said:

"The San Francisco Hospital Conference has appealed to the motoring public to be quieter passing hospitals. The fellow who leans on his horn and the motorcyclist with wide open exhaust can do great harm to the critically ill.

"The hospital administrators might at the same time abate the noisy traffic in their own corridors. We have checked around and we find we are not the only erstwhile patient who firmly believed the Gigglers and Pan Droppers Society convened just outside our door twice nightly at 11 p.m. and 4 a.m."

Anyhow, between the efforts of the staff inside and those of the press outside, St. Francis began to sound to a nonpatient as quiet as a tomb (which may not be the happiest comparison in the world).

Then Mr. Booth took sick. Nothing serious. Just some sort of crick in the neck, painful and awkward. His doctor ordered him away from his desk and into one of his own hospital beds for a day. That day was enough. Back in his quiet office, Mr. Booth called in his aides and announced grimly:

"This hospital is the noisiest damn place on the face of the earth. Let's do something about it."

Now, it is not to be inferred that Mr. Booth cares only for his own comfort, of that he had not already been doing his best to end the noises his patients complained of. It is only that it took a bit of listening through the ear of a patient to bring a complete realization of how loud a little noise can sound. As Mr. Booth put it to his staff:

"Have you ever heard that squalling call box? And who goes in for all the laughter and gossip in the corridors? And can't a mop bucket be set down without sounding like a blacksmith hitting an anvil?"

If things had changed around St. Francis after the tabulation of the noisy questionnaires, they changed still more extensively after the administrator took a day's dose of his own medicine.

Take the matter of the laundry chute door, for instance. The city fire department demands that such doors come equipped with strong springs so that, in the event of a fire, the chance of a draft will be cut to a minimum. Strong springs make loud noises, as 10 different patients in rooms near by had bitterly complained. The answer here was simple: The inner edges of the doors were lined with sponge rubber. No more slams.

Or take the endless complaints about the clanging elevator doors. St. Francis is unfortunately burdened with old-fashioned cage elevators, with heavy sliding steel doors at every floor. A modernization plan in the works includes the installation of modern silent elevators. Meanwhile, every possible means of quieting the old monsters is being employed: rubber stoppers where they can be used, oil where it's needed, and a lot of care on the part of the staff.

"A noise like falling tin right by my head," read one complaint, and there were others like it. This took a bit of sleuthing about the areas of the rooms where the complaints originated. It turned out they were all next to nurses' stations and that the noise of falling tin was caused by metal chart holders being dropped into wall slots. Here rubber and staff care come into play again.

The loudspeaker system for paging doctors disturbed other patients besides the boss. The system has three outlets on each floor, all set at a specific volume long ago, but now so out of phase that some whisper while others bellow. Mr. Booth plans now to have a volume control installed at each outlet for a more precise regulation.

There were a number of complaints about noise from loud-mouthed and late staying visitors. In fact, one patient complained bitterly about the noise produced by his own visitors. This particular beef was tossed out as beyond the province of the hospital, if not downright frivolous. The only answer to the legitimate complaints about inconsiderate visitors seemed to be a renewal of written and oral pleas to patients, a reminder that the man in the next bed and the woman down the hall are not intrigued by late laughter and loud talk. It seemed the only answer, too, to complaints about loud and late television and radio.

Concerning the noises originating outside the hospital, there were more specific remedies that could be—and have been—employed.

There was the matter of that man-



Things the patients would like: "walkie-talkies" to replace squalling call boxes; nurses tiptoeing instead of pounding on their heels, and mufflers for clinking glasses.

hole cover tiddlywink game in the alley at dawn. Mr. Booth played private eye and fixed most of the blame for the alley noises on garbage men, milkmen and a crew that delivered oxygen cylinders.

San Francisco's garbage men are an extraordinary and storied breed, men of gusto and Italians all, who tend to render grand opera arias as they go about their early morning work, accompanying the vocal music with a counterpoint of clashing cans. Mr. Booth got their promise and that of their employers that they would hold it to a hum or less in the area of the hospital. They will be re-reminded at intervals.

The milk deliveries posed a mystery. Patients swore that they were disturbed by the click and ring of bottles knocking together. Yet, the administrator knew, only milk in cartons is delivered to the hospital. Still, you can't satisfy people who know they hear certain sounds with a logical explanation. So the milkmen were told to quit clanging their cartons. As a matter of serious fact, they had been noisy, if not with bottles, certainly with slamming truck doors and clattering, metal-edged cases.

Then there were the oxygen cylinders.

"Have you ever heard an oxygen cylinder clang onto cement from the bed of a truck?" Mr. Booth asked his staff, wincing at the thought. "I have, and so have a lot of our patients. It's enough to wake the dead, let alone the sick in the hours before dawn. They won't be hearing that again. Rubber mats, specified and required."

It took Helen Jones, the St. Francis public relations expert and woman of all work, personally to put an end to another source of noise which was driving the staff as well as some of the patients mad. Right across the street from St. Francis is a medico-dental office building, with a prescription drugstore on the corner. For many months a delivery man for a messenger service had been in the habit of parking his pick-up truck in front of the building and turning up to full blast the volume of the two-way radio communication system connecting the truck with his office. His theory: He could receive messages from his dispatcher while delivering packages to doctors high in the building or while in the back of the drugstore waiting for a prescription to be compounded. He heard the messages all right, and so did everyone else for blocks around. There had been complaints to his boss, personal pleas to him. Nothing worked for long.



The Gigglers and Pan Droppers Society convenes outside the door twice nightly: at 11 p.m. and 4 a.m.

One day not long ago, shortly after the anti-noise campaign went into high gear at St. Francis, the messenger's radio blared out over the area. Miss Jones, who is somewhere around 5 feet tall and ordinarily the mildest of women, blew her top. She marched militantly out of the hospital, crossed the street and took up position next to the truck with the blasting radio. When the driver returned Miss Jones launched her attack. What she said only she and her victim know. It is said that he blanched. At any rate, he has not used his radio since in the vicinity of St. Francis Hospital.

There seems no permanent cure for the noise of horns, squealing brakes and roaring motors on the two arteries that merge outside the hospital. One great source of the trouble lies in the fact that drivers frequently stop to let out or pick up patients using the medico-dental building, double-parking to do so. Immediately traffic jams up behind on the one-way arteries—and then the honking begins. The police have been notified a hundred times, and each complaint is followed by the temporary posting of an officer there. But it never lasts. The whole traffic situation seems a permanent headache, with no sign in sight of a complete or permanent cure.

Some of the other complaints listed on the questionnaires were singular and rare and desperately hard to trace to their source. Nobody knew what to do, for instance, about the man who heard "hardware falling day and night" or the patient annoyed by "a generator right outside my room" (there wasn't a generator anywhere around).

But mostly now the St. Francis noises have been run down to their sources and eliminated where possible. And the moral remains: A sick superintendent in bed is worth a hundred patient complaints stacked on his desk.

Another San Francisco hospital—Mount Zion—has launched a different sort of program seeking silence. At Mount Zion a joint committee of representatives from the employes' council and from among department heads set aside September as "Anti-Noise Month." The matter arose, as it did at St. Francis, because in a series of patient questionnaires there were more complaints about noise than about any other single problem.

"Obviously, making Mount Zion a quieter place is of concern to the doctors," noted the hospital's staff newsletter, "not only because it directly affects the well-being and comfort of the patients, but because they too, it seems, are contributing to the amount of noise, mostly from informal hall conferences."

Highlight of the Anti-Noise Month at Mount Zion was a double contest: for a slogan and for the best idea on how to reduce noise. Prizes were two days off with pay or two tickets to the best show in town.

Meanwhile, Administrator Mark Berke announced he was looking into specific solutions to two major sources of noise at Mount Zion: under-pillow speakers for patient radios and television sets, and pocket radio-telephones for staff doctors, to cut down on the number of loudspeaker paging calls.



Topeka police direct evacuation of bedfast patients.

A fire in a home for the aged is expected to bring death and disaster in its wake. This one was the exception, thanks to the sound construction of the building, adequate sprinklers, and intelligent cooperation on the part of patients, administration and personnel

Why the Fire Story Had a Happy Ending

THELMA ANN REYNOLDS

BY ALL the rules, a conflagration in a home for the aged should certainly result in disaster. But reviewing the events connected with the fire that swept the Methodist Home for the Aged at Topeka, Kan., is like dreaming you have fallen 10 stories and waking up to discover you've only rolled out of bed. It could have been entirely different, but it wasn't. And it wasn't different because good planning, wise leadership, and farsightedness had prepared for just such an unwanted event.

The mercury climbed to 101° F. in Topeka last July 26, and it was on that day that fire broke out in what Kansas Methodists refer to as their "House of Happiness." It is one of 69 such homes affiliated with the Board of Hospitals and Homes of the Methodist Church. This residence of some 286 senior citizens, 65 per cent of whom are between 80 and 100 (the oldest member of the family is 101), was started as a church project in 1904. But it was not until 10 years later, in 1914, that the south wing of the present building was erected. By 1929 three other wings had been built, and in 1954 a new, thoroughly modern wing was completed, at a cost of more than a million dollars. Total assets of the plant now exceed $2.5 million. But the home is more than a building; it is a comfortable, attractive residence in which the "family" finds self-expression and happiness.

Thoughtful planning of the board of trustees and administrators who have served the home has resulted in a well rounded program for the residents. A quiet chapel for prayer and meditation and special services has long been a favorite spot. Recreation rooms, hobby shops, comfortable lounges, and bright sun parlors all make living in this home a joy. Individual flower plots adorn the lawns, and even in the large dining room there is a "homey" atmosphere. One gets the feeling that there is nothing *institutional* about this big home.

And so, July 26 started out to be just another good day at the Methodist Home. Some members of the family were resting quietly in their rooms; others were weeding their gardens; some were at morning prayer in the chapel, and others were just snoozing. On the fourth floor of the new wing, where the 102 infirmary patients were being cared for, the nurses were on duty, looking after the needs of their patients, some 75 of whom were in bed.

Downstairs in the kitchen the cooks were busy getting the noon meal ready, and over in the administrative offices the superintendent and his staff were going over the morning mail, attending to routine matters, and preparing for an afternoon meeting. It was an ordinary day like any other day—a little hotter than usual, perhaps; but one would hardly notice it with the good ventilation and air conditioning units. But at 10:20 on that hot July morning, the day changed completely and it turned out to be the most eventful day in the history of the home.

Nobody really knows how the fire started. The most popular opinion is that it was an attic exhaust fan. There have been many conjectures, but the

Miss Reynolds is public relations associate, the Board of Hospitals and Homes of the Methodist Church, Chicago.



"Out the window she must go." In a fire one leaves by the nearest exit.



Instead of being frightened, patients at the Methodist Home for the Aged took the fire calmly. Those who could walked out; others were carried.

superintendent admits frankly, "We honestly don't know." Nor is anyone sure who turned in the first alarm; but it was turned in, and pretty soon there was no mistaking the odor of smoke. The home was on fire.

Supt. Charles A. Byers is by nature a calm man; he is also a man of faith and action. When he realized what was happening, he kept his wits about him, and personally visited every floor of the building. Luckily, the blaze was a slow one, and he had time to do this. Calling out the residents, he told them that there was a "small fire" that should soon be under control. He did not advise evacuation at this time. He suggested that they return to their rooms and keep doors closed to prevent a draft. He added that he would keep them informed about what was going on. His suggestion was taken in the manner in which it was given—calmly, quietly, cooperatively.

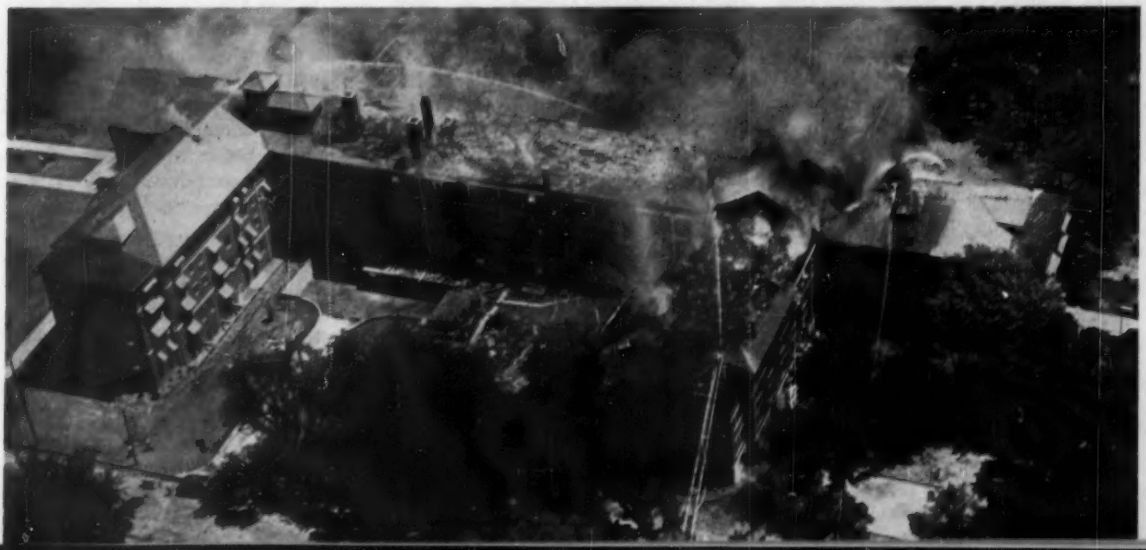
Actually, no one thought the fire would amount to much. It had started in the attic of the old (south) wing, and it was at this point that six Topeka fire companies started their battle. But several factors were against them. There was a serious lack of water in the water mains, which were not large enough to supply the amount of water needed for such an emergency; and the pressure was not great enough. The fire began to spread. Before the fighting was over, near-by Forbes Air Force Base and the Topeka Air Force Supply Depot had sent out fire-fighting equipment and men. It was beginning to look serious.

Partly because the residents were curious to see the "show," but mostly because of the probable danger of the smoke, Superintendent Byers and his staff felt that it would be necessary to take the old people to the porches which are located at the end of each of the four floors in the new wing. This was done in an orderly, well organized manner, and no one seemed frightened.

Because of the inadequate water supply, the flames spread to the attic of the new wing. Smoke was racing upward, outward and in almost every direction, and the 15 to 20 mile an hour winds made it look even worse. Fearing that many might be overcome by smoke, Superintendent Byers ordered evacuation.

Personnel of the home played an important rôle in helping the residents to get out safely. Mabel Haggman, R.N., chief nurse, remarked later that there was not a single incident

Firemen pour water on blazing roof of the home. The fire started in the attic of the south wing and spread rapidly, fanned by 20 mile an hour winds.



of hysteria or panic, no loud screaming or disorderly moving, and that the way in which every person conducted himself in the face of possible tragedy was amazing and gratifying. "They simply did what we asked them to," she said. "We led them out of the building onto the grounds, safely away from the building." Those who were unable to walk, including the 102 infirmary guests, were carried on stretchers, in chairs, or in the arms of firemen and helpers. Superintendent Byers, with members of the fire department, personally visited every room to see that everyone was safely out of the building. City policemen, highway patrolmen, reserve policemen, and Forbes Air Force policemen were on constant duty to see that everyone was well protected, and that the huge group of spectators did not interfere with safety.

Late in the afternoon, the last flicker had been extinguished, and the smoke had begun to settle. By that time, too, the human element was being well taken care of, for the task of caring for the almost 300 persons was a major production. Topeka did itself proud in putting the "good neighbor" policy into operation. Offers of help came from almost every public source and many private ones. Hospitals opened their doors; the Salvation Army, the Red Cross, the Junior Chamber of Commerce, the boy scouts, service clubs, ambulances, doctors, nurses, private citizens, the city bus company—all showed their willingness to help. And everyone did help.

Infirmary patients were taken to St. Francis (Catholic), Stormont-Vail, Topeka State, and Santa Fe hospitals. Other residents were temporarily taken to the Municipal Auditorium or to homes of relatives or friends. At St. Francis Hospital, the foresight of the administrator, Sister Kathleen, had paid off. Only recently she had purchased a number of war surplus cots because she had "always been worried about what would happen in an emergency." Twenty-six patients made use of them. At Topeka State Hospital, the fire seemed to have an indirect therapeutic value: When some of the old folks were taken there overnight, the state patients seemed to "come out of their shells" in an effort to help others. They forgot about themselves. Psychiatrists said *it* was incredible.

Then, like manna from heaven, came the offer from the Security Benefit Association that the residents make full use of its facilities—a beautiful (but vacant) hospital located on a hillside overlooking Topeka. This hospital, operated by the Security Benefit Insurance Company, is a 250 bed institution, but it had not been used recently because of the discontinuance of the project pending sale of the property. It was into these quarters that the residents, including the infirmary patients, were moved. Administrative offices were set up, and within hours, even meals were being served on schedule.

DAMAGE AMOUNTS TO $150,000

Damage to the home has been estimated at a probable $150,000, most of it the result of water and smoke. The roof was destroyed, and the wooden rafters in the old wing were burned through. Only the roof was damaged on the new wing. Except for a few soggy rugs and water soaked mattresses, the furnishings were almost untouched. R. C. Keeling, president of the board of trustees, stated that insurance would take care of the damage, and that the old building would be reconstructed similar to the new wing, making it an entirely modern plant. Authorities estimated that residents would be back "at home" within 60 to 90 days following the fire.

This happy state of affairs did not just "happen." There was a minimum of damage and no loss of life, thanks to preventive measures and good planning.

Good construction partly accounts for this success story. The concrete floor of the attic roof on the new building definitely saved the building, experts say. This concrete is laid 2½ inches on 14½ inch beams, spaced at 2 foot centers. Rock wool insulation is used throughout. Superintendent Byers points out that within the six months preceding the fire, approximately $50,000 had been spent to make the building safer; $20,000 alone had been invested in the installation of smoke doors during the last two years. Firemen say this was a tremendous help. During Mr. Byers' administration, fireproof exits were installed, and an old wooden stairway was removed, thus preventing a fire trap. Also, all floors with the exception of those in the old south wing are terrazzo, and all floors were connected by terrazzo stairways, elevators and outside fire escapes. In the old wing, which was made of brick veneer with inside wooden structure (this is where the main damage was noted), a sprinkling system, costing $10,000, had been installed on the initiative of home officials. If this had not been used, the intense heat would have gone through the entire building, instead of just the roof.

But there is more to the "miracle" than good construction and fire prevention measures. There is the quality of good leadership apparent in the entire staff of the home. The superintendent had not only insisted on safety measures, he had impressed upon his home "family" the necessity of remaining calm and cooperative in case of an emergency. He kept them informed of safety measures and devices, and he taught them faith and courage. Having good equipment is important; but having the confidence of your people is far more important.

Red Cross Director James Blazek said that he had "never seen a more composed group" in his life. Topeka Fire Chief William J. Cawker complimented Mr. Byers for the efficient manner in which the staff handled the residents: "They worked without any thought of their own danger. . . ."

Mrs. Loudell Frazier, licensing program supervisor of the State Department of Social Welfare, Topeka, said, ". . . the fact that there was no panic among the older folk . . . was due to their confidence and relationship to those . . . who work with them."

W. A. Lawson, building inspector supervisor of the Kansas State Fire Marshal Department, added his words of commendation: "This calm and collected attitude demonstrates confidence in [the superintendent] and his organization."

And from Dr. C. A. Ogg, Kansas state fire marshal, came these justified words of praise: "Possibly there has never been a fire of such potential magnitude with so many people involved that had such a happy ending. . . . It was a wonderful example of a perfect evacuation. The building was built to withstand fire, and it did. In my opinion, it was because the building was properly constructed, properly maintained and inspected, and also because of personnel properly trained, residents and patients above the average in intelligence and cooperation, and a well equipped fire department, police department, and volunteers who did a marvelous job. . . ."

What might have resulted in catastrophe turned out to be an adventure in faith and cooperation.

Business Methods Will Work in Hospitals

In spite of differences in motivation, and the complexities of hospital operation, the experts contend that business technics can be tailored to fit hospitals' needs, with resulting benefit to all parties

A MODERN HOSPITAL ROUND TABLE

EVERYBODY understands that hospitals are different from profit-making business, but any attempt to explain or define the precise nature of the difference is sure to start an argument among hospital authorities.

During the Atlantic City convention last September, The MODERN HOSPITAL sat in on one such argument. Taking part in the discussion were: Arthur Hibson, accountant and director of the Hospital Fact Finding Service at Clinton, Conn.; Robert Jones, administrator of Waukesha Memorial Hospital, Waukesha, Wis.; Harry Humbert, comptroller, John Hopkins Hospital, Baltimore; C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, and Mortimer Zimmerman, executive director of the Louis Weiss Memorial Hospital, Chicago. Everett W. Jones, vice president of the Modern Hospital Publishing Company, acted as moderator for the group. A recording of the discussion was made and is presented here, edited only to eliminate repetition and irrelevancies. —ED.

MR. HIBSON: Business methods are technics that we employ in trying to administer any organization. The reason I use the word "business" is that we can control any type of endeavor provided we suit the basic methods of control to the organization, but when we develop business methods, we develop them with the characteristics and peculiarities of business in mind. So an organization which is essentially a social organization does not necessarily lend itself to controls developed for a commercial organization and, therefore, cannot depend on controls which are designed with the motivation of business in mind.

DR. REROM: What do you consider the prime motivation of a business when you use this term?

MR. HIBSON: I can't help but consider that the prime motivation of business is to make a profit, because you see time after time that a business will fail if it doesn't make a profit, and we've seen businesses cut off parts or departments which did not produce a profit. However much they may have a professional or quality aspect in mind, that can't be produced unless it contributes in some way to a profit, even though it may be in an indirect way.

DR. REROM: Well, how about that middle ground between a social organization on the one hand and an operation for profit on the other—such as a public utility? Is a public utility more like a business or more like a hospital or social institution? If the profit motive is going to underlie the defense of your thesis, I want to know how far you'll go or how much difference it will make. Just a little difference, or a whole lot of difference?

MR. HIBSON: The public utilities are in business to make a profit; if they fail to make a profit, perhaps the utility doesn't close but the management changes, or they get their rates adjusted. There's a terrific furor when a utility fails to make a profit!

MR. E. JONES: There's one thing about the public utility business that may be different: Public utility rates are strictly controlled by government; this isn't true in other businesses. And yet, government recognizes that you can't have public utilities if the public utility doesn't make a profit, at least if it's privately owned. So they take that into consideration in setting rate structures.

DR. REROM: I merely wanted to see how much of what we discuss is going to hinge on the profit motive and how much on such other items as complexity or scope or geographic distribution and so forth.

MR. HUMBERT: Of course, the concept of business is to earn a profit. In a sense, voluntary hospitals make a mistake when they call themselves nonprofit organizations, because most voluntary hospitals—the smaller hospitals—must show some profit to keep open. They don't have endowments; they receive some support from the city or state. But hospitals keep using the word "nonprofit" and I believe we get ourselves into trouble. I suggest we would be better off saying that we're voluntary hospitals with profits, derived from our services, which go back into research for developing the care of patients.

MR. E. JONES: I could give you an argument on that. There are a

"We keep our heads above water by considering depreciation as an expense"

lot of hospitals that keep open and have been open for the last hundred years that have been in the red every one of those years.

MR. HUMBERT: I question that statement right down the line.

MR. E. JONES: I'm trustee of a hospital in Chicago that's been in the red every year since it opened up—60 years!

DR. ROREM: If I'm thinking of the same hospital, it's never covered its operation with income from patients. If that's the definition of nonprofit, there are many hospitals that do this. I think Mr. Humbert had in mind that the gross income of an institution may very well exceed its gross expense—income from all sources and expenses of all kinds.

MR. HUMBERT: That's exactly correct. I'm not thinking of the patient income alone, I'm thinking of gross income.

MR. E. JONES: The big problem is where the hospital gets the difference between its patient income and the amount it has to have to keep running, and that's a somewhat different problem than a business faces.

MR. HIBSON: I can give you an answer, at least a partial answer, to why hospitals can continue to show a net loss and yet continue to remain solvent. We show a net loss primarily because we've included depreciation as expense and we fail to show the transfer of funds from contributed capital to working capital. In a sense, this is supplementary income just as certainly as is depreciation expense. So we do show a loss if we've added the element of depreciation without showing the element of contributed capital funds.

MR. R. JONES: There are hospitals—and the one I am in is one of them—where patient income is the major source of income and must cover the expenses. Last year our total contributions or gifts were less than $2000—in a hospital with an operating budget of about a million dollars a year! It's a city owned hospital but runs voluntarily with no tax support whatsoever, and the philosophy in that town up until a few years ago was that taxes made it up so nobody ever contributed anything. We're gradually changing that philosophy. We're getting contributions, but they're very small, so, basically, our patient income must cover our expenses. There's no other source for the money.

MR. ZIMMERMAN: I think the point Mr. Hibson made was very true. Many hospitals today, by considering depreciation as expense, are able to create a cash fund, and that, frankly, is the way we keep our heads above water and assure ourselves cash in the bank. I think we should differentiate our cash position from our book position. Often depreciation will throw a hospital into the red. Cashwise it will show a net increase for the year, even though it has had a theoretical loss.

Another point which interests me is the motivation of business and the hospital. This difference in motivation may be overlooked in talking about control methods, because the basic control of hospitals, which are social organizations composed of very intricate human relationships, is not really in the statistical or accounting control. The real control is in the motivation of the entire institution. With two-thirds of our budget showing up as payroll, whether or not we can control expenses depends on how we motivate the people up and down the line.

DR. ROREM: Do you think that differentiates your nonprofit hospital from private business? One of the main areas of emphasis in business administration today is motivation—not motivation in contradistinction to the desire for a profit for a corporation as a whole, but ways in which individual employes can be made to feel responsible for the corporation's success and have some sense of participation in the venture. They call it incentive, they call it adventure, they call it self-expression—I would say in that particular area business and hospitals face exactly the same problem, possibly with business being more alert to the importance of it because they know that money alone won't buy loyalty or a sense of responsibility.

MR. ZIMMERMAN: We all know that industry for a long time has been concerned about motivation. We can go all the way back to the late 1930's, for example, to the well known experiment at Western Electric in Chicago, when investigators selected a test group of girls in the coil winding department. They told these people they were being selected for a special study and, while they didn't realize it at the time, this was a form of recognition appealing to the basic motivation of the girls, whose productivity increased steadily and surprisingly throughout a whole series of changes in working conditions. By the time they got through with this experiment, production was still rising while the room was so dark you couldn't read in it!

MR. E. JONES: What was happening there was that the people themselves felt they were part of the experiment, part of the show; therefore, they were interested. Most of you know Burleigh Gardner, former professor at the University of Chicago and head of his own social research organization now, who did some original research on hospital supervisory problems. He was convinced at first that he could take the same methods he used to motivate and train supervisors in industry and use them in the hospital, but later he decided that there were so many fundamental differences between the hospital and industry that he wouldn't undertake the job for hospitals without a lot more research.

DR. ROREM: What was one of those fundamental differences?

MR. E. JONES: The difference in control by supervisors from the top down. The administrator of the hospital does not have the same kind of direct control down through his organization, to all the people, that you have in industry, because of the cutting across lines of authority by doctors. That was the difference that


E. Jones


Zimmerman


Hibson


Rorem


R. Jones


Humbert

made Gardner decide you have to work out a whole new concept for training supervisors in a hospital.

DR. OREM: In other words, Dr. Gardner came to the conclusion that the physicians, who presumably were apart from the hospital, were really a part of the administration of what goes on in the institution and interfered—in either a desirable or undesirable manner—in the administration of the hospital.

MR. ZIMMERMAN: Still, many business control methods are useful in hospitals. The perpetual inventory is an example. Properly operated perpetual inventories, coupled with businesslike receipt and issuance of supplies, will control the utilization of supplies in every department. That's true in our own case and I'm very familiar with it. In addition, I know of excellent systems whereby the administrator, while he does not do the purchasing, has an opportunity to review everything that's purchased. Now, in the small hospital, for example my own, I sign every accounts payable check and I have an opportunity to know exactly what's been paid in my hospital every month. In a larger hospital that's not possible, it has to be delegated.

MR. HUMBERT: In the Baltimore area this is true; while the administrators in the larger hospitals do not have an opportunity to review each one of those requisitions—that authority has to be delegated. In our own case the department heads cannot order without prior approval of the administration of the hospital.

MR. E. JONES: They can order routine inventory stock items without approval. You're talking about new items.

MR. HUMBERT: They cannot add something to their operation that has not already been stocked in the inventory and reviewed. Unless it is approved, our purchasing department cannot order any equipment or supply.

MR. E. JONES: There's no difference between that procedure and the way industry runs.

DR. OREM: It seems to me what the hospital representatives have been saying here is that if they really use their perpetual inventories, then that particular business method is applicable to hospitals. Mr. Hibson might say, however, that even if they tried, they couldn't use them in a way a private industry would use them.

MR. HIBSON: That's right. When use of a hospital item becomes terribly excessive, then we find it, but we don't have the fineness of control that is possible in business. It isn't because we don't do something, it's because something is lacking in hospitals that is found in business.

DR. OREM: Suppose a hospital were organized as a proprietary institution, with profit as its admitted, if not primary, motive. Could business methods be applied to such a business hospital, organized for profit?

MR. HIBSON: I think you'd be more inclined to apply them there. I think you'd look behind the scenes more. If I gave you a report which showed a 10 per cent variation in your expected expense, and you were in a private hospital, you would be inclined to demand an explanation from that department. In most hospitals, department heads can only explain in very general terms, because nobody is accumulating the facts of actual consumption in the departments, while in business, because of the pressure for profit, administration is constantly pressing on department heads, and department heads are building up the facts.

DR. OREM: I'm trying to find out whether the reason we have difficulty with perpetual inventories, which is the illustration under discussion, is because of the complex character of hospital operations, with consequent difficulty of tracing the flow and destination of commodities.

If that is so, that difficulty still remains even if it's a proprietary hospital. Are you saying also that one of the reasons hospitals don't do this better is because they don't try?

MR. ZIMMERMAN: Actually there's nothing wrong with the business method of perpetual inventory control when applied to a hospital.

MR. HUMBERT: Then it's the failure of the hospital to take advantage of business methods when they can be used?

MR. HIBSON: Business invariably keeps departmental records of consumption. Those departmental records of consumption are motivated entirely because the management is profit-conscious and is pushing the department heads, and we don't have that in hospitals. Until the hospital accounting department automatically gives each department a count each month of the amount of supplies used and also has it available for the administrator, we don't get that stimulus on the lower echelons to be conscious of supply expense.

MR. ZIMMERMAN: The business method is sound. What you still say is that because we haven't used that as a stimulant to get the department heads more conscious of their usage the business method is no good in a hospital.

MR. HIBSON: No. Here's what I say: The inventory method, as it's used in business, is a tool of the purchasing agent, and the financial facts drawn off by the accountant are a tool of control. The knowledge of details within departments of a business simply does not occur in a hospital.

DR. OREM: I think we've done yeoman service to the illustration of a type of cost! I'd like to get Mr. Hibson's point of view on the matter of some business policy or business method with respect to hospital income or revenue that separates a business enterprise from a hospital—that of, say, pricing policy.

MR. HIBSON: The fundamental persuasion of a business is to sell. The collection is a fairly automatic procedure, generally accepted. In a hospital, the selling is a fairly automatic procedure and our persuasion is on the hospital community to pay.

DR. OREM: That is, in ordinary business you spend your effort per-

suading people to buy and take for granted they're going to pay, whereas in a hospital you take for granted they're going to buy, or at least accept the service, and bend your efforts toward getting them to pay for it?

MR. HIBSON: Exactly.

DR. OREM: Which is a rather sharp contrast in revenue philosophy.

MR. E. JONES: Our problem is to convince our customers that what they have to buy is priced right and they ought to pay for it. This is one of our big headaches. As a matter of fact, it probably isn't priced right, because we in the hospital field certainly have never adopted business control methods in setting prices of the things we sell.

DR. OREM: Do you mean the composite services of a hospital or the individual services made available through the hospital?

MR. E. JONES: I mean the specific rates. Why is a G.I. series priced at $35, $45 or $60? Is that based on cost?

MR. ZIMMERMAN: One of the new hospitals in Texas attempted to base its services on costs. The first thing that happened was the radiologist screamed bloody murder, because the charges turned out to be lower than those of the private radiologists. As a result, the hospital was forced to revise its charge schedule back to the traditional.

MR. HIBSON: Above or below cost?

MR. HUMBERT: In this case it was above cost. It was the community pattern.

MR. R. JONES: The x-ray charges were above cost to compensate for something else below cost.

MR. E. JONES: But not high enough to suit the radiologist, who set even higher rates in his office to get a bigger income. This same Texas hospital split its daily rate charge into one charge for room, another charge for meals, and a third charge for miscellaneous drugs, medicines, services and nursing care, in order to base its charges on the costs of these elements. They immediately got into trouble because another hospital in town didn't do that, and the community didn't understand. So this administrator who started out with a sound idea of costing his services and basing rates on cost got in trouble because nobody else would do it, and nobody understood what he was doing.

DR. OREM: Most merchandising and manufacturing enterprises do not make any great effort always to price their commodities on the individual calculated costs. Rather, they price the output of the total operation so that the revenue of the corporation exceeds the total outgo and, therefore, profit comes from the combined activities. In a hospital, I think this matter of what might appear to be capricious pricing of services can be explained sympathetically and intelligently as follows: The pricing of the services is carried on in such a way as to bring about an appropriate, proportionate utilization of those services. Certain types of services on a conventional cost allocation basis just couldn't be purchased by many people. For example, use of an operating room would be beyond the ability to pay of many patients requiring surgery. If, instead, hospital services were priced in such a way that, human nature being what it is, we would arrive at the best possible balance of professional services to raise quality, I think we could then justify all our charges.

MR. E. JONES: Granting that might be so, shouldn't the hospital at least be businesslike enough to know what the services cost and what they're losing or gaining on them?

DR. OREM: Precisely. I think that's important.

MR. E. JONES: Administrators ought to know what the cost is so they know whether they're losing or gaining and can support a reasonable increase in rates when they find it necessary to keep the hospital solvent. If we could also have our doctors see these costs, and we had them accurate enough o that we could convince doctors what our costs are, then we could show the doctors our problems, and could increase rates without so much fuss. That means we have to use business methods to arrive at costs, doesn't it?

MR. R. JONES: The rate increase that was put in at Waukesha was completely explained to the medical staff first, and it went to the board with the recommendation of the executive committee of the medical staff. When they saw the facts on what had happened to income and expense over a period of three years, since the last rate increase, the medical staff recommended to the board that the rates be raised and helped sell it to the public.

MR. E. JONES: If you hadn't had some kind of business control or fact accumulation methods in use, you wouldn't have had these facts at your command, you couldn't have presented them to your doctors, the doctors wouldn't have understood the situation, and you wouldn't have had their backing. So why do we say that we can't use business methods in a hospital?

MR. HIBSON: The methods business uses customarily are not just business methods, but many of them are methods that are common to any kind of control. The thing I'm objecting to is the precise forms in which we take things from business and apply them to hospitals. We did have some methods of measuring such things as consumption of supplies before we used the so-called business methods. But, actually, the difference between business methods and hospital methods is essentially the difference between the cash method and the accrual method.

DR. OREM: Which is cash and which is accrual?

MR. HIBSON: The hospital method is essentially a cash method and the business method is essentially an accrual method, and the reason it becomes that way is that somebody owns the assets of a business and nobody owns the assets of a hospital. A hospital must get all of its capital from the same essential source of revenue as it gets its operating income from. Whether we realize it or not, we're getting our working capital exclusively from our operations.

DR. OREM: Well, you use the term

"We are not collecting our accounts in any systematic way"

"cash basis" and "accrual" in a somewhat broader or different sense than the usual one. You're speaking of the total financing of the venture, particularly the cash basis for financing new plant and equipment as opposed to the accrual basis for financing the new plant and equipment.

MR. HIBSON: Let me be precise. I think we must keep our accounts receivable on the accrual basis, but I think it's very misleading not to adjust our income per patient back to the amount collected per patient. We put a reserve in now for uncollectible accounts. I'd be willing to bet that if every hospital in the United States changed that "uncollectible" to "uncollected," we would collect two million dollars more next year because this would emphasize the fact that we are not collecting in any systematic way.

DR. OREM: Are you saying the write-offs of the charity discount or allowances, and courtesy discounts and allowances, and contract discounts and allowances are too lighthearted and easygoing, and if the problem were studied more carefully these so-called courtesy, charity and contract patients might have paid more? Or do you mean that there is not a reasonable and businesslike method even to collect those accounts that do go on the books?

MR. HIBSON: You've got to separate your accounts receivable and analyze the facts not only to see the amounts due but also to see what's happened to them. We've got to go back to detail.

MR. E. JONES: As an example, you've got patients who pay their own way owing you money; you've got state, city, county and even township welfare departments paying for other patients' accounts that may be due. You've got compensation insurance, you've got Blue Cross and various other third-party payers, and within each one of those classifications you've got an aging of accounts. How old are they getting? What is the trouble with the welfare payments? What is the trouble with compensation insurance? What is the trouble with third-party liability accident cases? Where are we going? How are we going to get capital—working capital to finance this large amount of accounts receivable?

MR. HIBSON: That's it. I also want to see all these accounts listed, account by account, with a progress report and some notation of what has been done to collect and some indication of what has happened to them. When I was comptroller of a large hospital, I had a terrific amount of outstanding accounts—something like $400,000 worth—and it was impossible for me to go through that pile of accounts receivable. There was no summary. I couldn't get the picture. I started going through the accounts receivable, and I was lucky if I got through the letter B before I had to give it up as a bad job!

DR. OREM: Are you merely saying that by and large hospitals do not have a reasonably efficient method of attempting to collect their accounts—a reasonably effective method of collecting what they put on the books? I gather that you're not concerned about those that you deliberately write off for policy purposes, such as contractual agreements or courtesy allowances, or charity discounts, but you are suggesting that the collection methods are too informal.

MR. HIBSON: There are two things that are happening, and they're different. In the larger cities where there are a number of hospitals, there seems to be an extreme pressure to collect; in the smaller towns where there are only one or two hospitals, there isn't much emphasis on collection.

DR. OREM: You're talking now about patients who are responsible for their individual accounts. This has nothing to do with contract cases or third-party cases or that sort of thing, but the man who is responsible for his own account.

MR. E. JONES: In many hospitals you're in just as much trouble with a welfare account or compensation insurance or court account as you are with the patient who has to pay his own way, because you get behind and you don't realize how these accounts are building up. You see your total accounts building up, but you can't say exactly in what categories your accounts receivable are increasing, therefore you don't know where to start to put pressure. In the average community hospital around the country it's amazing how little information they have as to the detail of accounts receivable.

MR. ZIMMERMAN: But this is not because business methods are not applicable, it's because they're not being applied industriously and properly by the hospital.

MR. R. JONES: This is a problem industry doesn't have, because industry has credit policies before they charge. When you're buying at this hotel, if you're going to charge your account, arrangements are made in advance, and they've got to be good. They're not going to let you go out of here or take you in in the first place if they don't think you can pay. If you're buying from a big industry, they check your credit first before they send merchandise to you on a charge basis. Many industries during the war worked C.O.D.; when they delivered to the receiving dock, you paid. If you didn't have the money, they wouldn't deliver. We can't do that in a hospital, so we're faced with a credit problem that industry isn't faced with. There are no business methods to solve the problem. We've got to find one of our own.

MR. HUMBERT: In effect, we're financing the patient over a long period of time. It might be a year, it might be two years, and business methods are, or can be, applied in the follow-up of these accounts. The difference is just that we haven't extended credit, it has been forced on us. After credit has been forced on us, we can still use business methods of following the account, and eventually collecting the account.

This is the first section of the round table discussion on the application of business methods to hospitals. The second section will appear in the January issue.

Conclude Hearings in Iowa Suit

Hospital attorneys argue for continuation of laboratory arrangements, doctors blast corporate practice, seek "complete and absolute" control

DES MOINES, IOWA.—The district court trial of the lawsuit seeking to establish the right of hospitals to own and operate laboratories ended here last month after 13 weeks of involved testimony.

The lawsuit was filed in January by the Iowa Hospital Association against the Iowa State Board of Medical Examiners, the Iowa Association of Pathologists and (as intervenors) the Iowa State Medical Society.

Filing of the lawsuit amounted to a challenge of a 1954 Iowa attorney general's opinion that hospitals hiring pathologists and charging patients for their services were practicing medicine illegally.

During the course of the trial, which was recessed during the summer so the presiding judge and attorneys could take vacations, more than two million words of testimony were heard from 50 witnesses.

Then the trial ended on an unusual note:

District Judge C. Edwin Moore asked attorneys for both sides to present him with proposed conclusions of the issues involved — conclusions that would be supported by evidence submitted in the case and upon which Judge Moore could base a decree that the attorneys thought would be upheld eventually by the Iowa Supreme Court.

The proposed conclusions submitted by attorneys for the Iowa Hospital Association were simple and direct. The attorneys—Judge A. A. Herrick, Herschel G. Langdon and David Baker —said that from the evidence in the case Judge Moore should arrive at four conclusions:

"1. The ownership, operation and maintenance of laboratory and x-ray facilities, including the employment of nonmedical personnel, . . . are essential and integral parts of the lawful activities of a hospital. . . .

"2. The laboratory and x-ray facilities of a licensed hospital under present regulations must be operated under the direction and supervision of a licensed physician and no hospital has the right, directly or indirectly, to direct, control or interfere with the professional acts and duties of the physician in charge of the laboratory or x-ray facilities.

"3. A nonprofit licensed hospital and the physician or physicians who supervise and direct the laboratory and x-ray facilities may legally enter into any contract for compensation of each upon which they may mutually agree, including . . . a straight salary, a percentage contract or lease arrangement, or any combination of the foregoing. . . .

"4. A nonprofit hospital and a licensed physician who is in charge of its laboratory or x-ray facilities may legally enter into any mutually satisfactory contract or arrangement for the billing and collection of charges made to the patients for services rendered in said departments."

Philip H. Cless, an attorney for the defendant physicians, said in his closing arguments at the trial's end that the hospital "would continue to assume the dominant rôle" in negotiations between hospitals and specialists unless the court specifically limited the types of legal arrangements.

DEFENDANTS SEEK 15 CONCLUSIONS

The defendant physicians asked Judge Moore to draw 15 separate conclusions from the trial's evidence and to base his decree on them.

The 15 conclusions proposed by the physicians included:

1. That "medicine cannot be practiced by a corporation through the purveyal or sale of professional services. . . ."

2. That the "acts of the technicians (in laboratories) are essentially those of their physician supervisor."

3. That the physician's control of a laboratory "is diminished by the hospital employment and compensation of technicians, its provision of equipment and supplies, and its establishment of fee schedules."

4. That the physician "should be in complete and absolute control of all of the ingredients" of the laboratory.

Attorneys for the Iowa Hospital Association argued that if these conclusions were drawn, "the only way a laboratory could exist in a hospital" would be on a space-lease arrangement with the physician.

The Iowa Hospital Association's emphasis on the need for contractual flexibility that could only be obtained by local level negotiations was best voiced by Dr. Albert Snoke, president-elect of the American Hospital Association.

Dr. Snoke said he was not representing the American Hospital Association during the three days he acted as a witness in the Iowa trial.

Speaking of financial arrangements between medical specialists and hospitals, Dr. Snoke testified:

"I am convinced that there should be varying arrangements. I am convinced that what is satisfactory to one physician and one hospital and one community—and works out well there —is not necessarily the situation that obtains as a value in the other. And this you can find with two communities that are a few miles apart.

"I think that today we are looking at health care as a team approach. I think that it now is not just the doctor or a hospital, but that everybody is participating in this care for the patient today.

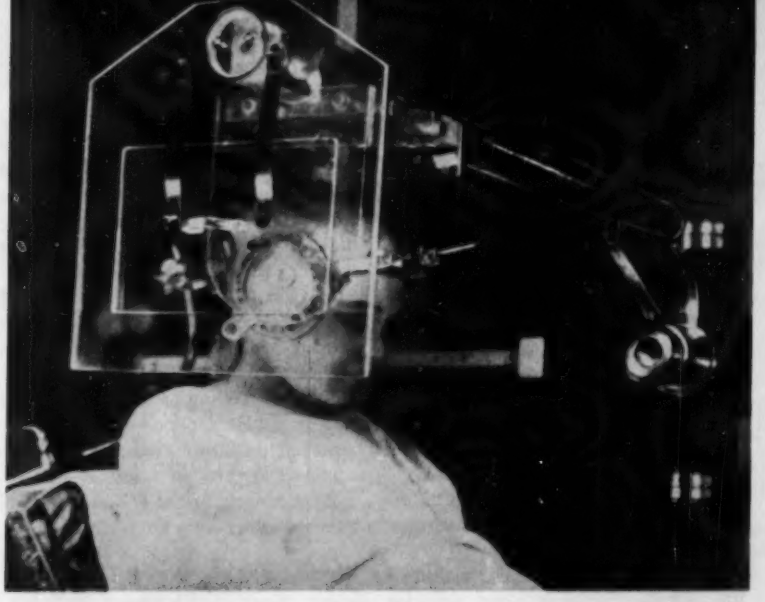
"If we were to try to lay out one specific pattern and say this is the way it must be followed, without any question at all the care of the patient would suffer. It might be the very best thing in the world for the patients in one area, but it might be the most complicated and the most difficult thing to do in another area.

"I wish I could be more eloquent in my feeling of the importance of the hospital today, not only in the care of the patient but in the rôle that it has in our present voluntary medical and hospital system. I think it is extremely important.

"You couldn't have medical care if you didn't have the physician. He is the basic component.

"But today the physician couldn't do an adequate job if he didn't have the

(*Continued on Page* 178)



Framework including grid (placed about ears) is fitted on patient's head and x-ray films are taken laterally. These films show up the entire brain against a grid, like a military grid map. Air-filled hollow spaces show up against this grid.

Electronics Comes to the Operating Room

Looking like a "TV space ship," this operating room has been designed and equipped for both standard surgical procedures and special technics used in neurosurgery

MARK BERKE

WHAT Dr. Milton Silverman, science writer for the *San Francisco Chronicle,* has aptly called "brain surgery by mathematics" is now in effect at Mount Zion Hospital, aided by an extraordinary and, as far as can be ascertained, unique new operating room.

The basis of this innovation in brain surgery, known technically as stereotaxis, was developed largely by Swedish neurosurgeons, and consists of an aiming device in the form of a special headgear. Fitted into place and adjusted according to measurements made from x-ray photographs of the patient's head, it enables the surgeon to insert an instrument—a needle or an electrode—deep into the brain, hitting the desired point within 2 millimeters. The procedure is so painless that it is generally conducted under local anesthesia, especially important because in many operations of this type, the patient's comments serve as an invaluable guide to the surgeons.

On the basis of previous work done in Sweden and in the United States, it appears that such pin-point methods of destroying brain tissue can help relieve intractable pain in many parts of the body, and may also be of value in hypertension, cerebral palsy, and certain types of epilepsy, as well as other disease entities.

The stereotaxic technic itself is not new, being now used in several hospitals in this country, but the operating room that has been built for the purpose probably represents the most advanced and complete of its kind in the world. Planned by Skidmore, Owings & Merrill, hospital architects, and a team of physicians, surgeons, physicists, biologists and electronics engineers, it is a mass of electronically controlled equipment that closely resembles a TV space ship.

One important feature is the separate control room, blocked off from the operating room by a pane of leaded glass, in which an engineer can control all the electronic devices, x-ray tubes, cameras and TV equipment.

Designed to be used as a standard operating room and for the special technics outlined, it incorporates the normal features of a modern facility, such as flush joint ceramic tile walls, flush lighting, oxychloride conductive floor, piped oxygen and suction, explosionproof outlets, air conditioning, stainless metal instrument cabinets, and explosionproof x-ray illumination.

As a facility for brain surgery through stereotaxis it incorporates the following special features:

1. A patient preparation room adjacent to the operating room. Here special headrests and sandbagging, as well as the gridded helmet, can be applied, fixing the patient's position on the operating table which can then be wheeled into the operating room. This room is equipped with storage cabinets, blanket warmer, and a utility sink. It is also equipped with large double doors to the corridor to facilitate transfer from gurneys or from a hospital bed when minimum disturbance is essential.

2. Within the operating room there is an entire wall of stainless metal storage cabinets.

3. The surgical light is a combina-

Mr. Berke is director, Mount Zion Hospital, San Francisco.

tion of three lights which can be tilted in any direction and moved up and down. All three lights are suspended from a track system which can be rotated to allow a wide range of lateral travel in addition to vertical travel from normal height down to 3 feet above the floor.

4. Two x-ray units are suspended from a single set of ceiling mounted tracks. Each unit can be raised or lowered and can travel laterally in a 7 foot wide band to cover the length of the room. This makes possible the widest range of positioning for x-ray photography and focusing from different angles for three-dimensional pictures.

5. The entire room is lead-lined for protection against x-rays used for photography or therapy and against radiation emitted in the use of isotopes.

6. The room is completely surrounded by a suspended copper screen which shields the electronic equipment within the room from outside radio and electrical interference. All electrical conduit, pipe, ductwork and all metallic surfaces entering the room are insulated by a fiber section where they intersect the copper shielding screen. The structural steel framework for the suspended ceiling and equipment is hung from porcelain insulators similar to those used with high tension power transmission.

7. The ceiling consists of flush cement asbestos panels which can be removed to permit changes and additions to wiring as technics develop.

8. Adjacent to the operating room, but with a separate entrance from the corridor, is the control room for electronic measuring and control equipment. Next to this room is a darkroom for the development of x-ray film, with a cassette pass box for exposed film from the operating room and for undeveloped film in cassettes. A projection port from the control room is used to project on the screen at the far end of the operating room the images of brain electric impulses and also x-ray film.

9. A large lead glass view window from the control room to the operating room permits the controls technician to command a complete view of the operating room.

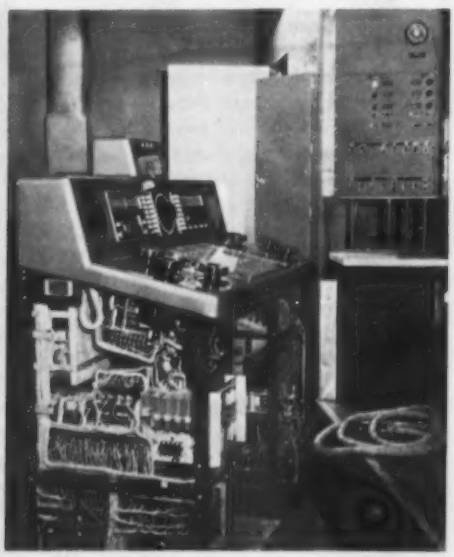
10. An intercommunication system is set up between the control room and the operating room for operating personnel. This system is tied into the hospital system for future broadcasting to other parts of the building.

11. The walls, ceilings, doors and window frame have been painted one color, a pleasant green. This tends to make the room appear larger and to minimize annoying contrasts. The control room has been painted a deep blue on all walls and on all exposed ducts and piping on the ceiling. Since the operating room illumination and surface color is much brighter than

View of the completed neurosurgery suite at Mount Zion Hospital, with special x-ray equipment lying on floor in packing cases, ready to be installed. In the center is the large lead-lined glass window opening into the unique control booth behind which an electronics engineer is stationed. He will manipulate all elements within the operating room, including the movable x-ray equipment, lights and so on. To the right of the control booth can be seen an x-ray viewing screen, with cassette pass box below it. Exposed film from the operating room can be passed through the pass box to the darkroom where it can be developed for use by the surgeons or projected through the opening at top right onto a screen located at the far end of the operating suite. To the left of the control booth can be seen another projection port through which EEG and other electrical impulses recorded during the operation can be projected onto another screen from the special control booth for recording all electrical measurements which is located to the left of the control booth. Special instrument cases can be seen at extreme right.

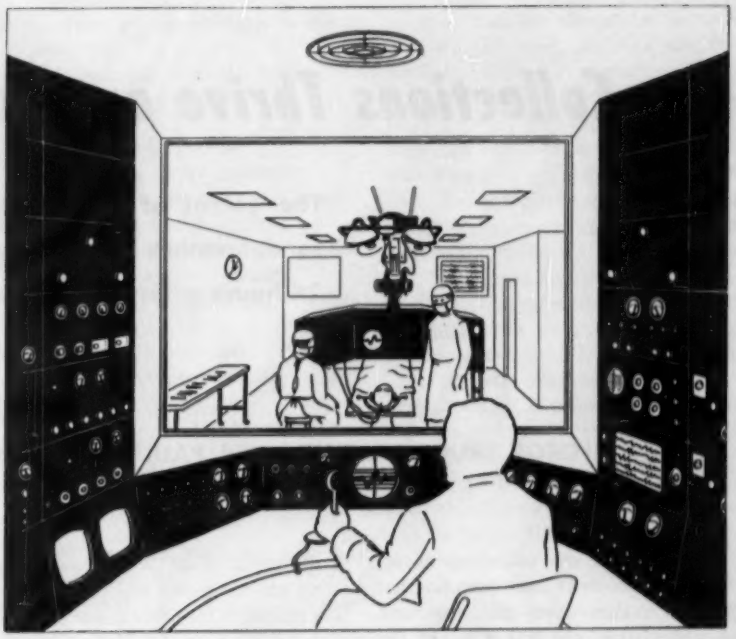


Inside the control booth, a closeup of complex x-ray equipment control before it is installed in the rest of the control panel, at right. The electronics engineer sits inside the area seen at right of picture. Doors in background lead to the x-ray darkroom and in the right foreground can be seen the door to the room in which all electrical measuring devices are kept. The entire x-ray unit can be controlled from the control booth, as can the projection of x-ray films from the darkroom into the operating room and electrical impulses from the electronics room.





Above: Closeup picture of the floor showing how the copper shielding is "hung" between two sets of 2 by 4 inch studs to prevent it from touching the outside wall at any point.



Above: Artist's drawing of the $75,000 "push-button" surgery suite planned at Mount Zion Hospital for its new neurosurgical institute for the study of human physiology. The operating room is both completely copper-shielded to enable surgeons to record minute electrical variations within the brain without outside disturbance and lined with lead so that radiant energy can be used freely. It is as nearly germproof, dustproof and explosionproof as possible. The operating room is seen here through a leaded window from inside the control booth. The electronics engineer is seen facing the surgery suite, a two-way intercom microphone in his hand. Before him are control panels which contain controls duplicating those on the surgeon's sterile control panel within the operating room. When the room is finally completed, the engineer, and the surgeons inside, will have duplicate controls operating all the instruments, including an electronic stimulator, ultrasonic and microwave apparatus, high frequency diathermy unit, and a variety of recording devices. There also will be a control by which the heavy x-ray apparatus—eventually to include both diagnostic and therapeutic units—can be moved in any direction on its carriage above the movable operating table, and raised and lowered hydraulically. X-ray films will be developed on the spot in a darkroom to the left of the control booth and projected within minutes onto the wall screen in the rear of the operating room. Immediately in front of the electronics engineer is an oscilloscope, duplicating the one on the operating room control panel, which shows tracings of the patient's electrical recordings. To the right of the engineer is a screen showing tracings from an electroencephalograph machine attached to the patient. The EEG machine is located in a room next to the control booth. The same EEG tracings show on the screen on the right at the rear of the operating room. Above the EEG screen on the engineer's right is an oscilloscope screen, which gives him a check on the workings of the apparatus at all times. To the left of the engineer is a complete TV monitor panel. A television camera, planned for the future, will be located in a nest of special lights just above the x-ray unit over the operating table. Table conduits, already constructed into the new building, lead to the hospital's auditorium, where 150 members of the medical staff will be able to see and discuss the procedure while it is going on.

that of the control room, the patient sees little of disturbing aspects of the control room equipment through the large view window. Also this color combination makes it easier for the technician to view the light operating room from a dark control center.

12. There are three electrical supply systems. A 208-120 volt A.C. system supplies equipment. A 240/120 volt ungrounded system supplies the x-ray equipment and that equipment not requiring a grounded system. A 120 volt D.C. system is used to illuminate the operating room. Alternating current, normally used for lighting, cannot be used because the lights would radiate electrical impulses which would affect the use of the diagnostic equipment.

During the course of construction of the operating facility, conductivity was carefully checked between the work in progress and the copper screen shielding. An automatic conductivity meter was devised which rang a bell whenever conductivity exceeded predetermined limits.

The operating room is air conditioned in the same manner as the other operating rooms in the surgical suite and has similar controls for temperatures which are in the range of 70° to 80°F. with a relative humidity of 55 to 60. The control room requires special air conditioning to reduce the temperatures generated by the electronic equipment from as high as 120° down to 80°F. for human comfort. Above the control room a special penthouse has been built for this air conditioning equipment and for electrical gear.

The complexity of the planning and the care taken to ensure conductivity were such that the final completion of the operating room was many months beyond target date. All concerned were agreed, however, that the lessons learned in the use of electronic instrumentation would be valuable as future guidance for any hospital concerned with similar developments.

Collections Thrive on Sound Credits

The secret of a successful credit system is to determine the source of payment within 24 hours after the patient has been admitted

GEORGE BRUCE CALDWELL and PAUL J. CONNOR Jr.

ALTHOUGH the collection of accounts of most short-term hospital patients occurs upon discharge and after discharge, the real work of the credit office is done while the patient is in the hospital.

"Because a hospital must admit all patients requiring hospital care, it is important to place each case in its proper category at the time of admission or as shortly thereafter as possible."[1]

The purpose of the postadmission period is to classify the patient as to source of payment. Each account must be considered and investigated. The source of payment should be determined within 24 hours after admission.

The problem of the postadmission period becomes a mechanical one. What device or mechanism can be used to accomplish this early classification? The proposed system of credit and collection presented here offers a simple method of classification and a subsequent method for gathering credit information.

The procedure begins in the admitting office where the following basic information is obtained: name and address of patient; name of doctor; occupation and employer; closest relative; last admission date; insurance, and person who will be responsible for the hospital bill.

This information on the admitting form then becomes the responsibility of the credit office. As the admission forms are completed and the information necessary for other departments is recorded, the forms are given the credit manager and, on the basis of the information obtained in the admitting office, the credit manager is able to classify the patient into one of the following categories.

1. No insurance or private insurance.
2. Group insurance other than Blue Cross.
3. Blue Cross.
4. Company compensation case.
5. Liability case.
6. Public aid.

After reviewing the information, the credit manager classifies the account by merely placing the corresponding number of the classification on the upper right-hand corner of the admitting form.

The classification has been made. This classification, however, was made on the basis of the information obtained from the patient at the time of admission. It is necessary to verify certain information and gather more data about the patient.

The code system of gathering information seems to be effective. This method requires the use of a credit clerk and may function as follows: After the credit manager codes the admission form according to one of the six categories, the form is given to the credit clerk. The back of the form is ruled blank paper for the clerk's use. The admitting form now becomes a follow-up for the recording of additional credit information. The classification number placed on the follow-up by the credit manager corresponds with the number on the card in the credit clerk's desk. This card contains a list of questions and instructions necessary for obtaining further information about the patient for credit and collection purposes.

Detailed written instructions for the handling of every case remove the human element from the job and, consequently, it is not necessary for the credit manager to rely on the credit clerk's judgment. For example, if the credit manager places the number "1" on the follow-up, the credit clerk pulls the corresponding card, obtains the information indicated on the card, and records the information on the follow-up form.

Careful consideration should be given to the content of these cards. They should state only what is necessary to determine accurately the source of the payment. Rockford Memorial Hospital has established the code system in gathering information and has used the system for some time with success.

The following is a suggested list of what may appear on each card for each classification. These questions may not apply to all communities and hospitals; however, the code system may be adapted to many hospital credit and collection procedures.

1. No Insurance or Private Insurance

1. Check bad debt file.[2]
2. Check employment and how long.

Mr. Caldwell is administrative assistant at Rockford Memorial Hospital, Rockford, Ill., and Mr. Connor is the associate director of the hospital.

[1] Gidman, Richard F.: Payment Control Through Study Risks at Admission. Hosps. 20:54 (July) 1946.

[2] Any hospital would do well to establish and maintain its own bad debt file containing names of all past hospital accounts that were unpaid. This is a valuable reference for checking readmissions.

3. Check city directory—see if he owns home.

4. Check for previous admissions. Find old account and advise amount of insurance paid, patient paid, and balance if any; also date of ledger. Was this a collector's account?

5. Check credit bureau.

6. If credit is poor, check doctor's office. Advise him of the findings and ask him what his experience as to credit has been with the patient. Ask if this person has been a patient at any hospital in town during the last couple of years (if old patient).

7. Advise credit manager of findings immediately if they look bad. Record all information on back of follow-up.

2. Group Insurance Other Than Blue Cross

1. Check bad debt file.

2. Verify insurance coverage (take special note of maternity). What does insurance pay?

3. Obtain assignment if needed (always have the assignment signed in the name of insured).

4. Special instructions for obtaining an assignment from patient:

A. Check with floor to see if patient can be seen.

B. Ask patient to sign (the name of the insured) so that we may process his or her insurance.

C. If patient questions assignment, advise him that we must have signature in order to release privileged information.

D. If patient still objects, do not attempt to force signature. Advise credit manager immediately.

E. If patient or any other person wishes to discuss hospital bills, please refer him to credit manager.

F. Record the foregoing information (steps 1, 2 and 3) on the back of the follow-up.

3. Blue Cross

1. Check bad debt file.

2. Call Blue Cross for number and type of plan. Take special note of maternity. Note: Give the patient's name, name of employed member of family (if other than patient).

3. If the patient has been in the hospital before (see follow-up), ask how many days are left on coverage.

4. Record this information on rear of follow-up.

4. Company Cases

1. Verify company case.

2. Name of person verifying.

3. Name of insurance company and address.

4. Where bill is to be sent.

5. Liability

1. Check bad debt file.

2. Check for group insurance.

3. Obtain assignment (see special instructions on card No. 2).

4. Get name and insurance company of person allegedly liable.

5. Check financing company of person insured (if riding in car) for medical payment insurance.

6. See if attorney has been retained for either side.

6. Public Aid

1. Phone local office for verification.

2. Complete and mail necessary forms.[3]

When the credit clerk has gathered the information indicated on the appropriate card and has recorded that information on the follow-up, the information is reviewed by the credit manager. The credit manager checks the information for insurance assignments, insurance benefits, and source of payment. If the credit manager is satisfied that the account is in order and will be paid, the data are filed until the billing procedure.

However, if the information indicates a credit problem, the following steps can be taken to establish a possible source of payment:

1. On the basis of the prognosis, estimate the length of stay and probable total charges.

2. If the patient can be seen, it may be possible to go to the patient's room and make the tentative financial arrangements.

3. Ask the relatives for further information and, if possible, make financial arrangements with them.

4. Check with social agencies. It may be possible at this time to find some third party to certify the patient and be responsible for the patient's charges.

5. It may be possible for the patient to be transferred to a hospital for the indigent, Veterans Administration, township hospital, or state hospital.

6. If there seems to be no possible source of payment for the patient, it may be well to get in touch with the doctor. Perhaps the doctor can arrange a home-care program for the patient. If the doctor is aware of the patient's

[3]These card instructions were adapted to this paper from the cards used at Rockford Memorial Hospital, Rockford, Ill.

ESSENTIALS OF A CREDIT AND COLLECTION SYSTEM

A method of distributing credit policy and obtaining credit information before patients are admitted.

A system of classifying the patient as to source of payment and a subsequent method of confirming this classification.

A system of in-house billing which is important to control of in-house receivables.

A method of determining credit problems and an established procedure for handling these problems.

A standard system of sorting and classifying accounts according to source of payment.

A device for checking accounts that are being paid in installments.

A standard procedure for processing insurance forms.

A standard procedure for collecting delinquent accounts.

A system of administrative controls of accounts receivable.

inability to pay, it may be possible to hasten the patient's discharge from the hospital.

The classification of the account in gathering information about the patient, the interpretation of the data, and the resulting source of payment of the account are all functions of the immediate postadmission period. The success of any credit and collections system in a hospital is often dependent on the time it takes to find and verify the source of payment for the patient's account.

This function, however, cannot be adequately performed without careful organization of the credit department, full cooperation among the hospital, doctor and community, and a thorough knowledge of the hospital, community and trade area.

IN-HOUSE BILLING

One device of credit and collections that may be used in the credit system is weekly in-house billing. The billing of patients while they are in the hospital has many advantages in terms of hospital income.

In-house billing often starts payment of accounts early. If the patient is made aware of mounting cost of his hospitalization, he is often willing to shorten his stay. One significant advantage of in-house billing is the fact that it checks the patients who become medically indigent while in the hospital. Often the patient may exhaust his funds for hospitalization and not be aware of it. In-house billing educates the patient concerning the cost of the medical care before it is too late.

Often, the hospital bill is not clear to the patient. If the patient has the bill while he is in the hospital, any confusion concerning hospital charges can be cleared up immediately. It is also possible that some erroneous charge may occur. If the patient discovers an error while in the hospital, it can be quickly corrected.

The procedure for in-house billing is simple but should be tempered with good judgment so it does not harm the hospital public relations.

Each week the credit manager goes through the file of in-house accounts. If unpaid charges indicate that the patient should be billed, the credit manager checks the follow-up to see if there are any special problems related to this case. If it is felt that the patient should be billed, a statement and letter are sent to the husband, wife, parent or nearest relative. No statements are sent to the patient in the hospital. If it becomes necessary to contact the patient, his condition is checked first and then the credit manager sees him personally.

The letter accompanying the bill should explain the credit policy, and the reason for the in-house billing, and request cooperation. It should be clear to the reader, yet as brief as possible. A possible letter to a patient's relative may read as follows:

"The hospital's policy of requesting that all bills be paid when rendered is no reflection on you or your credit rating. As a hospital, we are a 'nonprofit' institution. Because we operate without profit, we are unable to accumulate a reserve which may be used to meet our current operating expenses. We, therefore, must depend on current earnings to support the hospital. Your payment, when received, will be paid out almost immediately either to an employe as salary or to a vendor for medical supplies.

"Your help and cooperation in this matter will be sincerely appreciated."[4]

When the statement is sent, it is recorded on the back of the ledger card. These letters are coded for our own identification: one I (I) for the first letter and two I's (II) for the second letter. These codes are also recorded on the back of the ledger card.

If the hospital receives no answer within a week, a second letter requesting an appointment with the credit manager to make financial arrangements is forwarded to the same relative. This second letter used in the in-house billing is of some significance. It is this second letter that determines the patient's intent. This letter is worded more strongly and requests immediate payment. A second in-house letter may read as follows:

"Enclosed is an itemized bill for ..... You are in possession of the previously itemized statements. It is the policy of the hospital that all bills be paid weekly. If you cannot clear this account accordingly, please contact our credit manager immediately, and I am sure mutually satisfactory financial arrangements can be made."[5]

Often the information on the follow-up may indicate that this letter should be sent first. Because the letter is not a form letter, it can be changed slightly as is necessary for each case. If there is no reply to this letter, personal contact with the patient or relative may be necessary.

If the credit manager finds that the patient has no intent to pay, he has established this before the patient has left the hospital and not when the account is two months old.

Every consideration must be given to public relations during the in-house billing procedure. Certain exceptions may be made. People of importance in the community, patients who are heavily insured, patients on some type of public aid, and compensation cases may not be subject to in-house billing. Maternity cases and other short-term cases are, of course, not billed while in the hospital. The credit manager checks all follow-ups for such cases before sending the bill to the patient's relatives. In-house billing can be a valuable credit tool but can also hurt the hospital's reputation if not handled properly. If this function is performed in a businesslike manner and the handling of each case is given certain consideration, it can prove to be an effective part of the credit system.

DISCHARGE

The patient's discharge is also an important function of the credit department. According to Charles G. Roswell, "Wherever possible, patients should be discharged during regular business hours in order that the patient's account will be given proper attention by the business office. In this respect the cooperation of the nursing department must be obtained since the business office must look to this source for notice of patients scheduled to be discharged."[6]

It is imperative, then, that the patient be routed to the business office to make final financial arrangements on discharges.

The procedure at the cashier's desk must be brief and as pleasant as possible for the patient. The cashier has at hand the patient's itemized bill and the follow-up that was prepared at admission and immediately after admission.

If the follow-up indicates that the patient has insurance, the insurance is estimated and the patient is asked to pay the balance. If the patient cannot pay the balance, financial arrangements

[4] First letter used for in-house billing purposes at Rockford Memorial Hospital, Rockford, Ill.

[5] Ibid., second letter.

[6] Roswell, Charles G.: Accounting, Statistics and Business Office Procedures for Hospitals, pp. 183-4.

can be made. If the balance is minimal, arrangements, of course, are often not necessary. The cashier, with the information she has at hand, can adequately determine whether financial arrangements are necessary on insurance cases.

If the patient is known to the credit manager to be a good credit risk or if some third party is responsible for the bill, the credit manager has noted on the ledger that the patient may be discharged without payment. When the cashier sees this notation at the time of discharge, she merely informs the patient of the total charges and tells the patient the hospital will send him a bill. This simple system for recognizing pay patients at the business office may avoid embarrassment for the hospital.

The patient without insurance or third party payment is asked to pay on discharge. This should come as no surprise to the patient because he should be aware of the hospital credit policy before this time. It is clearly stated in our patient booklet. If the patient cannot pay on discharge and if financial arrangements have not already been made, the patient should be referred to the credit manager to make final financial arrangements.

USE INSTALLMENT PLAN

Probably the commonest type of arrangement is the installment payment plan. The credit manager must propose to the patient mutually agreeable installment payments at convenient intervals. These payments are based on the size of the bill and the patient's situation. It is a good idea to establish a maximum time limit to installment accounts as a matter of policy. If the credit manager can base his decision on the policy formed by the hospital administration, it will greatly facilitate his work.

At the time of discharge, then, there are three general classifications of patients: Those who pay the balance of the bill on discharge; those whose hospital bill is the responsibility of a third party (insurance or social aid), and those who cannot pay on discharge and must make financial arrangements.

The significant part of the discharge period concerns the latter group. No patient in this group should leave the hospital without making binding arrangements to cover the hospital bill.

This is the first section of Mr. Caldwell's and Mr. Connor's article on credits and collections. The second section, covering follow-up of accounts and administrative controls, will appear in the January 1956 issue of this magazine.

Agreement Reached in Mousel Dispute

Case against King County Medical Society and anesthesiologists settled out of court

SEATTLE.—An agreement in the case of Dr. Lloyd H. Mousel *vs.* the King County Medical Society and Washington State Society of Anesthesiologists was completed and signed here last month, according to the *Bulletin* of the King County Medical Society.

The agreement will become effective as soon as Dr. Mousel is admitted to membership in the King County Medical Society and Washington State Society of Anesthesiologists, the *Bulletin* said. Dr. Mousel would be admitted to membership in the King County Medical Society at its meeting early in December, it was expected.

Under the terms of the agreement, the Swedish Hospital agreed to abide by the terms of an earlier memorandum stipulating that anesthesiologists in private practice would be invited to apply for staff membership at the hospital and that the goal of the hospital "shall be an orderly evolution of anesthesia administration away from nurse anesthetists in favor of M.D. anesthetists as rapidly as surgeons increase their demand for M.D. anesthetists and as more such anesthetists become available in Seattle."

Other stipulations of the agreement were:

1. No salary, stipend or other form of compensation shall be paid by the hospital (either directly or indirectly) to Dr. Mousel or any other anesthesiologist for medical services rendered by them directly or indirectly to patients, including the supervision, assistance, advice or guidance of nurse anesthetists for whose services the hospital makes a charge to patients.

2. In any case where Dr. Mousel personally supervises, assists, advises or guides a nurse anesthetist administering anesthesia, or renders professional services to the patient preliminary or subsequent thereto, Dr. Mousel shall make a reasonable charge to the patient for the performance of such service except in those cases where in Dr. Mousel's professional judgment no charge should be made.

3. In such cases the hospital may bill the patient in his behalf and as his agent, and shall remit all receipts therefor to him. In such cases the amount being billed for the anesthesiologist's services shall be clearly identified as such and separately stated on the face of the bill. No charge will be made by the hospital to any patient for services rendered to that patient by any anesthesiologist or anesthesiology resident.

4. The board of trustees of the King County Medical Society will recommend the admission of Dr. Mousel to its membership, and all parties to the agreement "will do everything that is proper to accomplish Dr. Mousel's membership in said society" and in the Washington State Society of Anesthesiologists, Washington State Medical Association, and other organizations from which Dr. Mousel had previously been excluded.

5. The individuals and organizations participating in the agreement will cooperate in the establishment of a resident training program in anesthesiology at the Swedish Hospital.

6. The hospital may pay such reasonable salary as may be established by its board of trustees for teaching and training, and for administrative work, "neither of which shall include the supervision, assistance, advice or guidance of nurse anesthetists or anesthesiology residents in the actual administration of anesthesia, oxygen therapy or intravenous therapy."

Under its terms, the agreement was to commence at the time Dr. Mousel was admitted to membership in the King County Medical Society and the Washington Society of Anesthesiologists, and when letters of recommendation to these and other medical organizations, and the American Board of Anesthesiology, informing them that the action had been settled and that Dr. Mousel's relationship with the hospital is "ethical and proper," had been sent.

The agreement is then to remain in force "so long as Dr. Lloyd H. Mousel shall practice anesthesiology in the hospital, but in no event for a period of less than 10 years."

ABOUT PEOPLE

Administrators


Franklin P. Iams

Franklin P. Iams will become administrator of University Hospital of New York University-Bellevue Medical Center on January 1. Mr. Iams succeeds **Dr. Edward M. Bernecker,** whose death was reported in the August issue of The MODERN HOSPITAL. Mr. Iams received his M.H.A. degree from the University of Minnesota in 1948. He has been with the Rhode Island Hospital, Providence, R.I., since 1947, serving his administrative residency there and later becoming assistant director.

Charles D. Jenkins Jr. has been named administrator of the McDowell Memorial Hospital, McDowell, Ky., one of the 10 hospitals now under construction to serve the beneficiaries of the United Mine Workers of America Welfare and Retirement Fund. Mr. Jenkins is a graduate of the school of hospital administration, Medical College of Virginia, Richmond.


L. W. Hamblin

Leonard W. Hamblin has assumed the duties of administrator of Blessing Hospital, Quincy, Ill. Mr. Hamblin was formerly administrator of Deaconess Hospital, Freeport, Ill. He also served six years with the army medical administrative corps and was administrator of Kewanee Public Hospital, Kewanee, Ill. Mr. Hamblin is president-elect of the Illinois Hospital Association and a member of the American College of Hospital Administrators.

James A. Anderson, assistant superintendent at Lutheran Hospital, Fort Dodge, Iowa, is the new superintendent there. Mr. Anderson was formerly superintendent of Mitchell County Hospital at Osage, Iowa. He is first vice president of the Iowa State Hospital Association.

Joseph Taylor, assistant commissioner of mental health in Tennessee, has been appointed administrator of the Orange Memorial Hospital now under construction in Orange, Tex.

Marion L. Bittman has been named administrative director of Benjamin Rose Hospital, Cleveland. Prior to her appointment, Miss Bittman served as supervisor of nurses at the hospital. She is a graduate of the Frances Payne Bolton School of Nursing.


Leon Bennet-Alder

Leon Bennet-Alder, superintendent of Victoria Hospital, Winnipeg, Manit., has been named administrator of North Country Hospitals, Inc., at Gouverneur, Canton, and Alexandria Bay, N.Y. Mr. Bennet-Alder has also been associated with Dr. Rudd's Hospital, Toronto, and the Toronto East General Hospital. He holds a diploma in hospital administration from the University of Toronto and is a nominee of the American College of Hospital Administrators. Mr. Bennet-Alder succeeds **John E. Keene,** who has served as administrator since the three-hospital group was founded three years ago.

David A. Johnson has been appointed administrative assistant in the executive offices, Miami Valley Hospital, Dayton, Ohio. Mr. Johnson completed the University of Chicago program in hospital administration and served his administrative residency at the University Hospital of the University of Maryland, Baltimore.

Pearl Manning has assumed her duties as administrator of Baxter Memorial Hospital, Baxter Springs, Kan. Miss Manning was formerly medical assistant and x-ray technician for **Dr. H. L. Bogan** at Baxter Clinic, Baxter Springs. She succeeds **B. E. Dillon,** who is going into personnel work in private business.

Dr. Joseph Baker has accepted the position of superintendent of the Davidson County Hospital, Nashville, Tenn.

Sister M. Lucian, R.N., former director of nurses at St. Joseph Hospital, Hazleton, Pa., has been appointed administrator of St. Ann Hospital. She succeeds **Sister M. Medard.**

John C. Richard is the new administrator of Canonsburg General Hospital, Canonsburg, Pa. Most recently, Mr. Richard has been a hospital consultant in Atlanta, Ga. He has also been associated with hospitals in New York, Pennsylvania and Alabama and is a member of the American College of Hospital Administrators. He succeeds **Edith W. Baily,** who has resigned after 10 years of service there.

Mrs. M. Symington has been appointed administrator of the Bruce Peninsula and District Memorial Hospital, Wiarton, Ont. She succeeds **Miss D. M. Baycroft,** who will become administrator of the General and Marine Hospital, Collingwood, Ont.

Roger L. Rothrock, assistant administrator of Prince Georges General Hospital in Cheverly, Md., has been named administrator of Rolling Hill Hospital and Diagnostic Center, Elkins Park, Pa. Mr. Rothrock has also served on the staff of the surgeon general of the U.S. Army in Washington, and is a member of the Association of Military Surgeons.

Mother M. Coronata, O.S.F., is the new mother superior at St. Anthony's Hospital, O'Neill, Neb. She was chief technician at St. Joseph's Hospital, Minot, N.D., from 1944 to 1955.


Col. P. W. Mallory

Col. Philip Wallace Mallory has been appointed chief of Walter Reed Army Hospital's outpatient service at Walter Reed Army Medical Center, Washington, D.C. Col. Mallory entered the Army Medical Corps in 1937. He has served as executive officer and commanding officer of evacuation hospitals in North Africa, Italy, France and Germany and as surgeon for the army section of the U.S. military commission to Brazil. Most recently, Col. Mallory has been associated with the medical information and intelligence division of the army surgeon general's office.

John H. Shephard, administrative resident and assistant director at Stormont-Vail Hospital in Topeka, Kan., has been appointed administrator of Anclote Manor, Tarpon Springs, Fla.

Mary Brannon is the new administrator of Geneva County Hospital, Geneva, Ala.

(*Continued on Page* 188)

Who Should Do the Surgical Prep Shave?

For best results, this study shows, the "prep" should be the responsibility of the operating room, performed by carefully selected, adequately trained nonprofessional workers

RUTH PERKINS KUEHN

MECHANICAL cleansing of the operative field is a function which has been delegated for the most part to nursing service. The procedure is important in preventing the introduction of pathogenic organisms, which normally reside on the skin, into the surgical wound.

The quality of the local shave preparation has varied considerably and in many instances has been unsatisfactory. If poorly done, the welfare of the patient may be jeopardized. The procedure is overly time consuming when repetition is necessary. Variations in procedure, in the proficiency of personnel performing the procedure, and in equipment being used, have resulted in the following problems:

1. What department should be responsible for the procedure?
2. Should it be performed by professional or nonprofessional personnel?
3. Can the procedure be simplified and standardized?
4. When and where should student nurses be taught this procedure?

The objective of the surgical prep shave study was to answer these questions and to establish a procedure which can be used by any hospital for improving this function.

This is the third in a series of articles from the University of Pittsburgh on the results of studies of operating room nursing procedures. The first two articles, covering the processing of used rubber gloves and standardizing surgical setups, appeared in the October and November issues of this magazine. The fourth, and concluding, section will appear in the January issue.

Mrs. Kuehn is dean of the school of nursing, University of Pittsburgh.

In order to collect representative data concerning the surgical prep shave procedure, 124 questionnaires were sent to as many selected hospitals in the 48 states and the District of Columbia. In addition, seven questionnaires were completed by students in the operating room management course at the university, who collected these data from Pittsburgh hospitals. Ninety-three questionnaires from the mailing list were returned from 45 states and the District of Columbia. Seven questionnaires from the seven students were returned. One questionnaire was returned unanswered. Thus 100 of the 131 questionnaires distributed were completed and returned. This is a response of 76.3 per cent.

Inasmuch as this is an unusually high return, we feel that it indicates the interest and need for a study of this type. We wish to thank the many hospitals who participated in this survey by contributing the necessary data. In addition, we wish to thank the various individuals who contributed their time and opinions, especially those operating room supervisors who were asked for specific opinions.

The preoperative surgical prep shave, referred to subsequently simply as the "prep," is defined as follows: "preliminary preparation of the operative site and surrounding area for surgical procedure."

The factors that constitute a good prep are: (1) proper area; (2) elimination of all hair and desquamating epithelium; (3) no nicks, cuts or scratches on the skin.

Prerequisites for obtaining a good prep are:

1. A proficient operator. Assignment of responsibility to one or more carefully selected and trained persons.
2. The patient relaxed and in the proper position.
3. Good equipment. The two most essential items included in equipment are a good razor and a good light.
4. Good procedure. A written procedure which is simple and practical, and which helps assure good results.

GENERAL CONCLUSIONS:

1. The function should be the responsibility of the operating room.

In the questionnaire we asked the various hospitals to evaluate the effectiveness of the procedure in their own institutions. These answers are summarized as follows:

Very good	18 or 18.2%
Good	39 or 39.4%
Satisfactory	33 or 33.3%
Unsatisfactory	9 or 9.1%

Two hospitals did not answer.

These four groups were analyzed to determine whether there were common factors which might be significant in the evaluation.

The results of this analysis are shown in the table on the following page. This shows that as the evaluation of the prep changed from unsatisfactory to very good, the department which had the major responsibility for the function changed from the nursing unit to the operating room. Best results seem to be obtained, there-

Evaluation of Effectiveness of Procedure

Evaluation	Operating Rm. Function	Nursing Unit Function	Central Service Function or Other
Very Good	66.8%	27.7%	5.5%
Good	58.9%	41.1%	
Satisfactory	45.5%	54.5%	
Unsatisfactory	11.1%	77.8%	11.1%

fore, when this function is the responsibility of the operating room.

2. Nonprofessional personnel, *carefully selected* and *adequately prepared*, can and should be used to perform this function.

Results of the questionnaire show that of the 100 hospitals which answered, 98 were using an orderly or male attendant to prep male patients; 33 were using practical nurses, and 28 were using nurse's aides to prep female patients. These are all nonprofessional workers. Apparently there is no reason they cannot be used satisfactorily if carefully selected and properly trained to perform this procedure.

3. The procedure can be simplified and standardized by: (a) establishing a written procedure which can be used as a pattern by any hospital; (b) delegating the responsibility for this procedure to one department; (c) assigning the performance of this procedure to as few workers as possible; (d) determining the best equipment for use, and (e) centralizing the maintenance of equipment.

4. Undergraduate student nurses should be taught this procedure by the operating room staff concurrent with their practical experience in operating room technic.

Of the 100 hospitals answering the questionnaire, 84 had been or were affiliated with a school of nursing. Of these 84, 69 are using student nurses to prep patients. In some hospitals only a specified number of preps were done to fulfill school requirements. In others, the majority of all preps were performed by student nurses.

ANALYSIS OF SURVEY RESULTS:

1. Order—Who orders surgical prep?

Surgeon 65
Resident 44
Intern 30
Standing order 5

The survey indicates that there is no set pattern in use in hospitals for ordering the surgical prep. Comments accompanying the questionnaire indicate that this area needs standardization. The lack of orders often causes undue delay to the personnel responsible for this function. Investigation into the medical legal aspects indicate that there is no reason for having written signed orders for the surgical prep. (The only exception to this might be for brain surgery or for the face and neck of female patients.)

Since it is recommended that this function be the responsibility of the operating room, we recommend that standing orders in that department will cover most operative cases. Orders for exceptional cases should be left at the time the case is scheduled. The prep list can then be set up according to the operating room schedule, whether they be done in the patient's room or in the anesthesia room. In this way the operating room then has complete responsibility for scheduling and performing of all preps.

2. Responsibility—Which department is responsible for this function?

Operating room 53
Nursing unit 46
Others 4

The questionnaire definitely shows that this is becoming more and more a function delegated to the operating room. Inasmuch as the shave is the prelude to the surgical preparation of the skin at the onset of the operative procedure, it is logical that this function should be the responsibility of the operating room personnel. These employes are the ones who must continue with the preparation of the operative area and are therefore likely to be more cognizant of the necessity of having a high quality prep.

It is recommended that the responsibility for this be delegated to the operating room.

3. Instructions.

a. Who is responsible for teaching this procedure?

Operating room nursing service 40
Nursing units 48
Central supply service..... 1
Nonprofessional supervisor 5

The analysis shows that the operating room is responsible for teaching the procedure in 42.5 per cent of the hospitals surveyed. The nursing unit is responsible in 51.1 per cent. Even though the operating room is responsible for the procedure in 50.5 per cent of the hospitals, it is still only responsible for 42.5 per cent of the instruction.

It is recommended that the operating room be responsible not only for the function but also for the training of the personnel that performs the function.

b. Is this a written procedure?

Yes 88
No 11

An analysis of the written procedures returned with the questionnaires indicated a wide variety of overall content and the amount of detail included. The hospitals that did not have written procedures indicated the need for them and other hospitals indicated that their procedures are in the process of being revised.

4. Who performs the procedure?

a. Female Patients:

Graduate nurse 67
Student nurse 69
Practical nurse 33
Nurse's aide 28
Resident or assistant resident 2
Intern 3

b. Male Patients:

Graduate nurse 19
Student nurse 20
Intern 10
Professional barber .. 8
Orderly 92
Male nurse 1
Male attendant or aide 6
Medical student 2

An analysis of this information indicates that there is considerable variation in the level of the personnel performing the procedure. Both nonprofessional and professional workers are doing the prep within the same hospital. This means that a large number of people are being trained for the procedure. Nonprofessional personnel is used more extensively in the larger hospitals.

Experience in preps for undergraduate student nurses has been eliminated in some instances; has been restricted to a specified number in

others, and has been extensive in still others, with the student nurses performing the majority of all preps. Inasmuch as the undergraduate student nurse is still performing this procedure in some hospitals, it may be desirable to include the fundamental principles of the surgical prep in the curriculum. If this is done, instruction and experience should be a regular part of her operating room training.

It is recommended that nonprofessional personnel, *carefully selected* and *adequately prepared,* be used for this function wherever possible. This is another instance in which the nonprofessional worker can be used to expedite the work of the professional nurse.

5. When is the procedure performed?

Day previous to operation—96
Day of operation—16 (usually emergencies)
Others—11 (orthopedic and neurosurgical)

An overwhelming majority performed this procedure the day previous to the operation. The reasons behind this seem to be that it was the most convenient time for the personnel involved. This has come about as a result of the early operating room schedule, the change of shifts of the nurses at 7 o'clock in the morning, and the heavy work load of patient care in the early morning hours that did not leave time to prep the patients.

Inasmuch as we recommend that the operating room personnel perform this function in the operating room suite immediately prior to surgery, we suggest that it be performed on the day of the operation. However, if anesthesia rooms are not available in the operating room suite and the prep must be done in the nursing unit, it can still be done on the day of operation. The advantages to its being performed on the day of operation are: (a) the shorter the time between the prep and the operation, the cleaner the area will be; (b) unnecessary repetition of the prep is eliminated on canceled cases; (c) there is less of the adverse psychological effect which is caused by having the prep performed so far in advance of the operation.

6. Where is the procedure performed?

Patient's room 88
Treatment room in nursing unit.....16
Operating room (actual) 5
Anesthesia room in OR suite 6

Analysis shows that in a large majority of hospitals, the surgical prep is done in the patient's room. The lack of treatment rooms on the nursing unit and the fact that the function is still being delegated to the nursing unit are the determining factors. Also, many hospitals do not have an anesthesia room in the operating room suite. In most cases, this leaves little or no choice but to perform the procedure in the patient's room.

Wherever possible, it is recommended that the procedure be performed in the anesthesia room of the operating suite. In this room, we can have three prerequisites for a good prep. These are: (a) the best position, (b) a good light, and (c) a relaxed patient. This also eliminates the need for transporting the equipment throughout the hospital. Recognizing the fact that the patient's room and bed must be used in many instances, we suggest that the operator be trained to recognize the need for proper approach in preparing the patient mentally and physically for the prep.

a. The psychological effect of a surgical prep performed in the patient's room cannot be overlooked by the personnel performing the procedure. An explanation of why the procedure is being performed and protection against exposure and embarrassment are essential. If these preliminaries are carried out properly, the patient is more inclined to be relaxed and in a cooperative mood.

b. The personnel must be trained to put the patient in a position similar to that used during surgery.

Further information was collected through direct contact with experienced operating room supervisors who at the present time are performing this procedure entirely or partially in their operating room suites.

The results of these contacts show that:

a. The procedure was delegated to the operating room at the suggestion or request of the surgeons.

b. The quality of the preps has been improved.

c. The operative schedule was not slowed down by performing this procedure in the operating room. Estimated times given for all preps ranged from 2 to 15 minutes.

d. This method has been satisfactory to their anesthesia departments.

e. Patients have offered no complaints.

f. Operating room nursing personnel favors this method.

7. Who checks the prep?

Head nurse on unit..58
Clinical instructor 14
Operating room nurse 56

The results indicate that this portion of the procedure is about evenly divided between the charge nurse on the nursing unit and the operating room staff. In some instances, the responsibility of performing the prep and checking the quality of the prep is delegated to different departments.

Even if the prep is checked by the head nurse on the unit, the prep is rechecked by the operating room nurse when the area is exposed for further skin preparation. This is unnecessary repetition. Inasmuch as the operating room nurse has the better opportunity and is probably the one most appreciative of a high quality job, this should be her duty. If the quality of the prep is unsatisfactory, it is the responsibility of the operating room nurse to make the correction. The personnel performing this procedure is directly responsible to her and therefore she has the best control and will be able to see that inferior preps are not repeated.

8. Equipment

a. Which department is responsible for the equipment used?

Nursing unit 40
Central supply service 12
Operating room 53

This indicates that there is no set pattern for the handling of the equipment. On the nursing units, where direct care is given to the patient, and where other responsibilities may take precedence, this type of equipment is often neglected. When the operating room assumes the responsibility for doing the surgical prep, as recommended in this report, it can handle the equipment in the same manner as other supplies.

Central supply service, which is primarily concerned with the cleaning, preparation and assembly of professional supplies, can be used to advantage in the delegation of responsibility for this equipment.

(*Continued on Page* 102)

Patients Like These Four-Bed Wards

Contrary to popular belief that patients prefer private rooms, Montefiore Hospital's experience proves that they are actually happier in the multiple-bed accommodations

JOHN D. THOMPSON

HOW do patients feel about single rooms? Have hospitals "oversold" the private room to those patients for whom such an accommodation is not medically indicated? Is this desire for maximum privacy which has been influencing the trend of hospital design for the past few years an answer to the wishes of the patient or is it an exaggerated response of planners and architects who still remember the old open public wards?

Experience at Montefiore Hospital, New York City, with a new semiprivate room plan, where patients are placed in either a four-bed or a one-bed room depending on the patient's condition, indicates that many patients actually prefer multiple bed accommodations.

It takes a rather self-sufficient individual, even in these days of television, to occupy himself for from 14 to 16 hours a day. Such factors as the patient's occupation, amount and type of education, and social milieu all enter into the ability to escape the boredom of being alone.

While the majority of beds at Montefiore were assigned to ward service, assignment of patient accommodation based on medical criteria rather than on ability to pay was always the policy. Since charges for ward patients are uniform, decision as to the type of accommodation based on the amount the patient can afford is not considered. Although our ward service has been cut back over the past few years, we still maintain this procedure for service cases.

Mr. Thompson is assistant director of Montefiore Hospital, New York City.

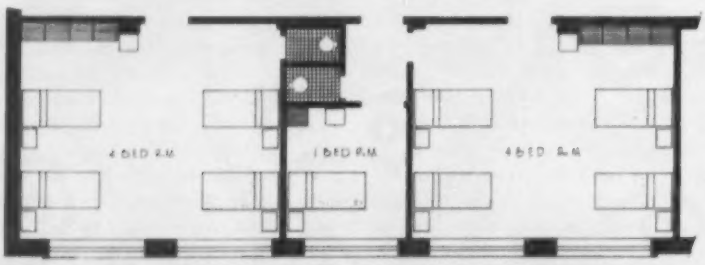
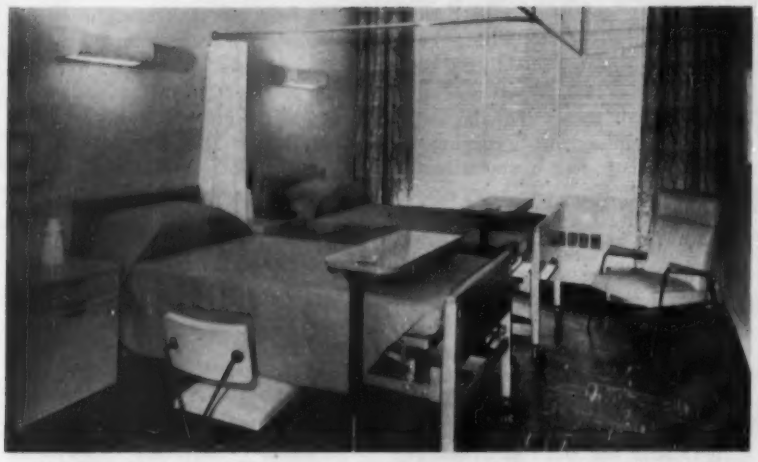


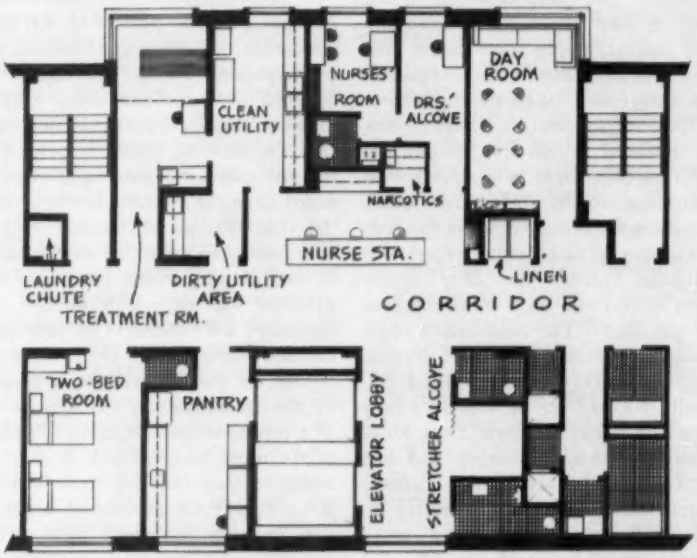
Fig. 1. Diagram of two four-bed wards with single administrative room between. Below, left: View of the four-bed unit; right: single room.







Above: Typical two-bed room in the new annex. Below: Fig. 2. Plan of the "core" adopted as the standard work unit and used on each patient floor.



Each ward nursing unit has several two-bed rooms used for those whose medical condition warrants a certain degree of privacy. These patients may be critically ill, noisy, or just in need of multiple treatments at all hours of the day or night, while others, whose illness may be disfiguring or odoriferous, should be away from the public life which exists in multiple bed accommodations. Assignment of these double rooms is decided by the resident physicians and nurses on the ward.

When Montefiore began considering the construction of a pavilion devoted primarily to private and semiprivate patients, all concerned with the planning felt that these facilities should be designed to permit assignment of beds according to medical indications. The pattern that evolved (see Fig. 1) contains two 4 bed rooms separated by a small single "administrative" room. This administrative room is not sold as a private room but is used for those semiprivate patients whose medical condition requires a single-bed room. Charges for these rooms are the same as for two-bed rooms and, consequently, the Blue Cross contract covers the full price of the accommodation.

The administrative room fits in with the toilet arrangement between the two 4 bed rooms. This toilet is actually shared by five patients but, since the occupants of the single room are primarily those who are seriously ill and consequently unable to use the facility, it was felt that the toilet-patient ratio was not, in fact, too high. It is interesting to note that we have accommodated 38 patients in these four-bed and one-bed units in the same square footage (8200) as the floors above which, with the standard one-bed and two-bed rooms, have a capacity of but 30. The staff required to run the floor is about the same as for the smaller units. The nursing staff appreciates the flexibility allowed by one-bed and four-bed pattern and considers the four-bed rooms much easier to handle than doubles or singles.

This room arrangement solves the largest single administrative and nursing problem arising from the multiple bed accommodation, *i.e.* what to do with the disturbing patient. Because we are able to keep the four-bed room free from noisy or extremely ill patients, occupants of these rooms are satisfied, even though many of them believe that "semiprivate" entitles them to a two-bed room. The decision to move the patient to a single room rests with the administration, acting on the recommendations of the private physician, the resident staff, and the charge nurse on the floor.

In practice, the system works out exceptionally well, though not exactly in the way we had predicted. The office of the director was prepared for a great deal of pressure on the part of patients, relatives and attending physicians for single rooms. Actually, however, many patients resist being moved into these single accommodations. It is not because these rooms have the connotation of "death rooms" but rather that the patients claim they will be "lonesome" or bored in a single room, and most of them welcome the time when they may move back into the four-bed accommodations. We have found these multiple bed rooms based on the pattern described easier for nurses to work in, cheaper to build, and adaptable to the varied needs of our semiprivate patients. Future building plans at Montefiore are going to continue this arrangement of multiple semiprivate accommodations with single administrative rooms.

In designing the remainder of the nursing unit, the planners utilized the really important advantages available to those who are enlarging an existing institution, *i.e.* the knowledge and experience of those presently working in the hospital.

The contribution of those employes concerned with direct patient care and

the routine operation of the institution is particularly valuable and may well be more pertinent to the problems of a specific institution than are standardized solutions lifted from architectural manuals. The engineer, the housekeeper, the laundry manager and, above all, the nurses are all anxious and able to share their special knowledge with the architect and administrator in roughing out floor plans, selecting building materials, and determining the amount and type of equipment needed.

When the new pavilion was still in the schematic stage, regular planning meetings were held between the assistant director in charge of construction and those department heads who would be directly involved in the operation of the new building. Since most of the new pavilion was to be occupied by private and semiprivate patients, the nursing department was most actively concerned with the design of the building. A "nurses' committee," composed of the nursing executive, the future supervisor of the new annex, the educational supervisor, and several head nurses, began working with the assistant director and even with the architects themselves. These planning sessions not only gave the nurses a definite feeling of pride in and identification with the new building but, when transferred from the old section of the hospital to the new, they were already fairly familiar with the floors so that the initial period of confusion attending the opening of the new unit was minimized.

The nurses were rather wary at the first meeting, expressing the opinion that if hospital architects were required to work for at least six months as aides or orderlies before they took out T-squares many poorly planned patient floors would never have been built and the lot of nurses would have been a much happier one. When it became obvious to our nurses that the architects had no intention of relieving the nursing shortage even temporarily, the give-and-take at the meetings resulted finally in what has proved to be an efficient, nursable patient floor.

It is interesting to note the nurses' reactions to some of the classical questions in patient-floor planning which are reflected in the plan of the "core" (Fig. 2) adopted as the standard work unit and repeated on each of the patient floors.

In spite of the fact that Montefiore Hospital has been serviced by a central supply unit for two years, the nurses felt that a "dirty" utility room was necessary. This small area (45 square feet) is used to strip and store the used central supply trays before collection, as an alcove for trash cans, and as a storage area for enema equipment.

The bedpan sterilizer-flusher was also included in this area, despite the fact that each toilet is equipped with a flushing nozzle. The nurses claim that there are occasions when the bedpan cannot be thoroughly cleaned with the toilet flusher. The "dirty" utility room is also used as a collecting area for specimens. The clean utility room contains a generous amount (146 cubic feet) of storage space required primarily for storage of central supply trays and sterile solutions. Since Montefiore is a horizontal hospital and does not have tray conveyor service, storage requirements on patient floors are increased if continuous trips to central supply are to be avoided.

When the question of nurses' lockers on the floor *vs.* centralized lockers in the basement was brought up for discussion, it was the chief nurse who decided the location. Lockers were put in the basement so that nurses would report on the floors in uniform. Purse lockers 1 foot by 1 foot were put in the nurses' office, however, and a vanity was provided in that same area.

The nurses requested that an area be set aside for the house physicians in order to relieve the traffic in and around the nurses' desks. This area should be close enough to the nurses' stations so that charts will be available to both the doctors and the nurses and should have enough privacy to permit the doctor to interview relatives or to have small conferences during rounds. The doctors' alcove was included in the plan for these purposes.

A professional decorating firm was brought into the picture to act as a consultant in color and furnishings in the patients' rooms. The results can be seen in the illustrations. Unfortunately, the illustrations do not indicate the striking colors employed in the plasticized wall covering. It can be noted from the pictures, however, that the room has an uncluttered appearance, primarily owing to the inclusion of two drawers in the bottom of the patients' lockers, which obviate the necessity for dressers or auxiliary cabinets.

One of the innovations suggested by the decorators was the substitution of a copper colored bedspread in place of the usual white spread. It must be admitted that this departure was instituted over the protests of many of the employes, including some of the laundry personnel. In practice, we have found that the use of a colored spread has cut down the laundering of bedspreads by an estimated 30 per cent since the nurses do not change the colored spreads as often as they changed the white ones.

The nursing floors were equipped with audio-visual communication, with piped oxygen and suction, and with individual telephone jacks for each bed.

The pavilion has been in operation since March 1953 and the floors have proved to be efficient. Although the entire building program at Montefiore has not been completed, the patient-visitor-service traffic from the rest of the institution has been handled with remarkable ease. This is one annex which no one can tag with the epithet-cliché that it "growed like Topsy."

ADMINISTRATIVE CAPSULES

THE SIMON-PURE administrative technician working within the executive offices of the hospital and giving no thought to the world beyond its walls is being driven out of his shell, like the physician, by the sheer force of social and economic circumstances.

THE BEST OF ALL HOSPITALS is the one that has found the way to maintain a personal kind of protective interest in every patient from beginning to end.

HOSPITALS ARE MORE than first-aid stations and, moreover, they were not created for the care of curable patients only.

HOSPITAL EXECUTIVES must bear in mind that the physician is entitled to economic security and that his patients must bear the burden if he does not have it.—E. M. BLUESTONE, M.D.

Consultant Gives Record Librarians a Lift

and improves the hospitals' chances for accreditation

RAE L. SMITH

IN ARKANSAS, as in other states, hospital administrators are anxious to meet the requirements for approval by the Joint Commission on Accreditation of Hospitals. Prior to the survey by the Joint Commission in the spring of 1954, there were two fully approved hospitals in northwest Arkansas, one new hospital on provisional approval, and one new hospital, which had not yet had inspection, but had requested it.

Inasmuch as 410 of the possible 1000 points in the point rating system of the hospital standardization program can be earned by the medical records, the administrators believed that more points could be earned and the quality of their medical records could be improved by group supervision in the medical record department. There are eight hospitals in northwest Arkansas, ranging in size from 32 to 60 beds. In none of the eight hospitals was there a registered record librarian. Three were eligible for registration, however, on the basis of experience.

Shortly after the organization of the Northwest Arkansas Hospital Council, which is composed of eight hospitals, preliminary plans were made to seek the services of a registered record librarian to establish a training program for the record librarians in the area. In a few weeks such a person was found. She held a college degree, was from an approved school for medical record librarians, was registered, and had had experience in several medical record departments. The salary to be paid was $30 per day. Seven of the hospitals entered the contract. Some of the hospitals requested her services for as much as four days a month, some three days, others only two, and a contract was set up whereby each participating hospital agreed to pay by the day for the number of days agreed upon. The contract was for one year, but at the end of the year's time was renewed for a few more months.

One hospital in the council withdrew from the contract by mutual agreement, but another hospital outside the council requested the consultant's services.

WORKED WITH ADMINISTRATORS

The consulting record librarian lived in a town centrally located in the area, and drove each day to the hospital where she worked. She worked closely with the administrators of the hospitals, and made suggestions as to improvements that might be made. She worked the hours the local record librarian worked.

In most of the hospitals there was only one record room worker, whose duty it was to act as medical secretary to the doctors on the staff, maintain the daily analysis of hospital service, and attend to all the many duties ordinarily performed by such a worker in the small hospital. So, at times she was too busy to receive instruction, and in this case the consulting record librarian made use of this time to set up the disease and operation index or to code and index. Only one of the hospitals was using the "Standard Nomenclature of Diseases and Operations" before the consulting record librarian came.

She not only worked on the days she was paid, but organized a class which met one Saturday each month to give instruction to all the record room personnel from the hospitals in the council. These Saturday classes were held at one of the member hospitals, each hospital having at least one class during the 18 months of the contract. The group supervisor gave instruction on the various phases of medical records, using Edna Huffman's "Manual for Medical Records Librarians" as a textbook. Other suitable books in the field were recommended for reference. The subjects covered included statistics, medicolegal, organization and management, medical terminology, medical record library science, and history of medical records. She also taught the use of the "Standard Nomenclature of Diseases and Operations" in coding and indexing. Later on, some time was spent in discussion of the work of the tissue committee and the records committee in the hospital.

One outstanding program for one of the Saturday classes was a day's workshop conducted by an instructor from a well known school for medical record librarians. An extension course in anatomy was organized, sponsored by the University of Arkansas with an orthopedic surgeon as the instructor. This class met one evening weekly for one semester, and was attended by most of the record librarians and some nurse's aides.

As I mentioned previously, three of the record librarians were eligible for registration at the time the medical record supervisor came. One record librarian took time off to attend a school for medical record librarians, and returned to her work in the fall eligible for registration. The three record librarians are now registered. Standard nomenclature was being used in only one hospital in the council. Now it is used in seven hospitals in the council. Four of the eight hospitals in the council are now fully approved by the Joint Commission and some of the others will ask for inspection shortly.

Presented at the Midwest Hospital Association meeting, Kansas City, Mo., 1955.

Miss Smith is medical record librarian, Fayetteville City Hospital, Fayetteville, Ark.

Success Story of a Service League

is told in dollars and sensitivity to the hospital's needs

MARY DEYO

"WE'RE not a lazy woman's organization."

Those six words from Mrs. George C. Davis, president of the Methodist Hospital Service League, Peoria, Ill., are the short short success story of a most remarkable group.

No, they're not lazy. From a standing start in 1951 with five charter members and $150 capital, the Methodist Hospital Service League in four years has (a) raised its membership to slightly more than 100 enthusiastic women, and (b) paid $31,000 into the building program of the hospital.

In fact, the league paid off its last $25,000 five-year pledge in *a year and a half,* and is now working on its second $25,000 five-year pledge.

Privately, Dr. W. T. Smith, executive director of the 400 bed hospital, opines, "They'll pay it off in two years."

Now, in the gift shop, the Christmas card sale and the gift show, the Methodist Hospital Service League is not using brand new ideas to raise money. But the league has added enthusiasm, ingenuity, system, efficient business methods, low operating costs as a nonprofit volunteer organization, and a monopoly location to well tried projects as stepping-stones to its resounding financial success. . . . And there are still others, as we shall see.

How has the league done it? What can other volunteer organizations learn from their accomplishments? This is the story.

In 1951, Dr. Smith and some of the staff doctors at the hospital were trying to heighten the public's awareness of the hospital's work and its desperate need of funds for expansion. They thought a women's organization which could make money for the hospital and interpret its work to the community might accomplish their aim.

The first five women they talked to included the wives of two staff physicians. These women were both enthusiastic and civic minded. They decided on a gift shop in the old lobby of the hospital as the first money-making project.

They recruited 25 more members; each one put in $5 dues to get the gift shop going—and they were on their way.

Mrs. John Blossom, one of the original five and this year's gift shop chairman, recalls the first one, opened Sept. 25, 1951: "We had a little hole in the wall in one corner of the old lobby. When we wanted to lock up at night, we had to put screens around our merchandise and then lock chains around the screens.

"At first, we tried to staff the shop with volunteers all the time, evenings and week ends included, but the husbands objected."

Now the gift shop makes gross sales of between $35,000 and $40,000 a year ($37,813.56 in 1954) in a space approximately 11 by 17 feet off the lobby of the Methodist Hospital's new eight-story, $3 million hospital addition opened in January 1953.

Clerking, buying, bookkeeping are big jobs in a volunteer operation of this kind and can be headaches.

But in a short four years, the service league has figured out a smooth-running, though complicated, system. Many of its methods may be helpful to other volunteer groups planning their own gift shops.

To take the clerking first:

Every member of the service league works in the shop one morning (9 to 1) or afternoon (1 to 5) every other week four months at a time. For evenings (5 to 8:30), Saturdays and Sundays (1 to 4), the shop uses part-time help, older women paid by the hour.

The service league doesn't use any sort of training pamphlet for sales-

League members run a shuttle service to and from the Christmas gift show at the Country Club of Peoria, thereby making friends and improving trade.

Photograph from Peoria Journal-Star





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women or its members in general. "We're too new yet and don't need one," seems to be the feeling so far. In the shop, the new salesgirls work with the experienced ones twice, then start out on their own the third time.

Hospital employes, nurses, proud new fathers eager to buy their first-born a toy, interns and student nurses, doctors, and visitors push open the shop's glass door casually or purposefully all day long.

Everything they buy must be listed on the daily sales sheets. The gift cart girls fill out slips for their sales, too, so there is a complete record. Then the buyer for each department cuts her own sales slip off the sheet to do her bookkeeping.

(Since the shop is a nonprofit venture, it pays no sales tax, only federal excise tax on the appropriate items.)

As Mrs. Blossom says, "Our buying system is unique and amazing. Each buyer is a law unto herself. The ones in the gift department go to the Chicago shows twice a year. They all paste the price tags on their merchandise, keep up their own inventories, store and arrange stock in their allotted spaces in the shop, do their own bookkeeping and ordering. There are buyers for gifts, jewelry, toys, magazines, toiletries, stationery, candy and the gift show. They meet the first Friday of the month with the personnel chairman, the gift cart chairman, the two shop treasurers and me."

The shop bookkeeping is done on a double-entry system. Total sales (all cash) are recorded weekly, totaled monthly, and then transferred to a ledger.

Disbursements, made only by check, are in two categories: (1) merchandise purchases with their shipping costs are recorded by departments; (2) expenses (supplies, salaries, equipment).

A balance sheet and statement of operation are prepared at the end of the year and the books are audited annually by a professional accountant. (Note: The shop books include gift show sales and purchases.)

How has the gift shop grown? In 1954, sales had more than tripled the first full year of operation, which was 1952.

Net profit last year was 29.2 per cent; cost of goods sold, 65.4 per cent; expenses, 5.4 per cent (capital, help, supplies). Last year's sales totaled $43,313.56. Approximately $11,000 was made from gift shows at the country club and the hospital, or 25 per cent. Cart sales totaled $5500, or 12 per cent. Per cent of profit by departments ranged from 20 per cent in candy and magazines to 60 per cent in handmade articles.

When the patients can't visit the gift shop, the gift shop visits the patients, via three aluminum service carts like those used in restaurants. As Mrs. Theodore Durfee, gift cart chairman, says: "I don't think this is primarily a money-making activity. It's more an accommodation to patients."

Mondays, Wednesdays and Fridays from 10 a.m. to 1 p.m., the gift cart women don aqua smocks like those their sister saleswomen in the gift shop wear and wheel their carts up and down the corridors of the two medical and surgical floors and the maternity floor. Each cart saleswoman works one day every other week, as do the shop volunteers.

The cart girls always work with the nursing personnel by inquiring at the floor desks about any patients who may be too ill to see them. No patient is ever urged to buy, but everyone possible is visited during the gift cart's rounds.

"I feel you don't really realize what the organization means to the public until you work on the cart," says one service league member.

And another corroborates: "I've had people come up to me in a store or at some public affair and say, 'I remember you came around with the gift cart when I was in the Methodist Hospital.' Yet neither of us knew the other's name."

In contrast to running the gift shop, working on the gift show, and turning out handmades the year around, the service league regards its sale of personalized Christmas cards (another money-making feature since the beginning of the organization) as a summer project.

But just because it's short on time doesn't mean it's short on profits. Not when you consider last year's figures: 30,500 cards sold for a profit of $1940.91.

For the first couple of years, an artist member of the league designed a special card. However, as Mrs.

In the hospital's 11 by 17 foot gift shop the Service League sells more than $40,000 worth of merchandise a year.

Photographs by George W. Sommer.

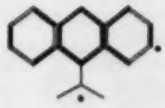


A surgical patient looks happy to see the league member who has brought one of the three aluminum gift carts.



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Syrup 10 mg./5 cc.	4 fl. oz. bottles	1.53 each
Tablets 10 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	2.13 each 20.24 each **170.00 each**
Tablets 25 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	3.03 each 28.79 each **243.00 each**
Tablets 50 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	4.23 each 40.20 each **317.00 each**
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Richard Radley, this year's Christmas card chairman, phrases it: "Everybody got tired of giving and receiving the same card, so last year we began offering a variety, personalized or not, as the buyers preferred.

"After our sample books are on hand, we send out a card to our mailing list of 1275 announcing the names, addresses and phone numbers of the nine committee members at whose homes the books can be seen. We try to scatter the locations through town so they'll be easy to get to.

"Then it's just a matter of calling the league members and asking them to bring themselves and their prospective customers over so we can take their orders.

"It saves lots of time and lugging around to bring the customers to the cards. . . . All the books are on display at the gift shop and the gift show after our first drive."

"If we can't sew, we can glue; or if we can't glue, we can cut buttons off a card."

That cheerful statement from one of the Methodist Hospital Service League members who admits she's not the "handy" type is a clue to tht effectiveness of the production department.

Responsible for turning out all the handmade items which are a "specialty of the house" for both the gift shop and the gift show, the production department has to fit its workers to the work—and the other way around.

Mrs. Donald Beste, production chairman, says, "This is a tremendous job but somehow does not lend itself too well to organization. It depends on people's talents and interests. We keep a record of every member's abilities—machine sewing, hand sewing, plain or artistic painting, and so forth."

And for some statistics bearing out Mrs. Beste's first statement: About 1500 different handmade or hand-decorated items were turned out in 67 workshop meetings last year. Six groups met more or less weekly. Another ran almost all year.

Total handmade sales in 1954 were $5400: $1400 in the gift shop, and $4000 at the gift show.

Mrs. Beste works with her subchairmen to decide on the types and quantities of handmades that are to be turned out. Each one has charge of a single category of items for the gift show—personal, household, Christmas, children, aprons and hand-knits.

When the subchairmen have purchased their materials (the Service League has charge accounts at several Peoria stores) they hand them out for individual or workshop production, depending on what is to be made.

Even though the production department sets high standards of craftsmanship, workshop articles must be items that can be made in specific stages, can be done by a group, and can be "retouched" easily. Fine sewing, artistic designing, big knitting jobs usually are taken care of by members with special talents who work in their own homes at their leisure.

MEET AT MEMBERS' HOMES

"Many hands (and many tongues) make light work" describes league workshops aptly. In the height of the production season, two or three may be meeting each week in conveniently located homes around Peoria. One advantage of these neighborhood meetings is that members can drop scissors or paintbrush and run home at noon to fix their children's lunches. . . . Whatever the project, the workshop members continue to meet once a week until the item is finished, then go on to another.

Even though Mrs. Beste is concerned with getting the work out, not the bookkeeping, she cautions: "One thing is very important—you must try as hard as you can to keep accurate accounts." Two other rules: "We try to write off the entire cost of every project as it is completed. . . . We also put in a cost on such items as snaps, binding and thread. It's easy to let them slip, but if you do it too much, you end up not getting true figures or an accurate picture of your costs."

Pricing is a problem, Mrs. Beste admits. Generally, the group which makes the article sets the price. "On handmades, we try to get what the traffic will bear—literally. But we have to scale our prices a little lower than the local specialty shops."

This year the Methodist Hospital Service League's Christmas gift show, under the chairmanship of Mrs. Scott Ruby, was held October 25 and 26, at the Country Club of Peoria. Hours were from 10 a.m. to 8:30 p.m. Tuesday, luncheon and dinner served by reservation; Wednesday, from 10 a.m. to 2 p.m., luncheon only.

The way responsibilities for the show were divided may prove helpful for other volunteers contemplating their first big attempt of this kind.

First, there's a general chairman who decides on the physical layout. It's her job to show to best advantage all the merchandise: toiletries, jewelry, toys, gifts, stationery, candy, handmades, wrappings, Christmas ornaments, and Christmas cards.

Two gift show buyers have as their special task rounding up unusual items for the show, ranging in price from $3 to $25. They also buy the Christmas ornaments and decorations that are to be sold.

The regular gift shop buyers also purchase for the gift show in their own departments. Each department is given a quota for the gift show. It is separate from their shop quota but everything left from the show must go back to the shop to be sold.

And then there are chairmen for decorations, properties, finances, record-of-sales, luncheons and publicity.

One of the special features of the Methodist Hospital Service League's gift show is the free "shuttle service." To save the inevitable long walks from and to parked cars, about a dozen league members patrol the road by the country club all day long, picking up shoppers in their own cars and taking them back and forth.

Eye-dazzling! That's the way to describe the first shopper's view of the gift show. Here a jeweled evening sweater, there a family of roguish clown dolls, at the end of an aisle a Christmas tree hung with brilliant foil chains.

In every possible way, the league makes it easy and pleasant to succumb to buying temptations. Each customer receives a shopping bag at the door. She may fill as many as she likes and pay for them all at once. However, the league accepts checks only from members and customers they know.

Then, there's no need to pay the saleswomen. Instead, each customer empties her shopping bag on a counter in front of a checker at the only exit (to help prevent pilferage). The checker, in true supermarket style, calls off the prices; the adding machine girl totals them; the customer pays her bill; that's all.

At the end of the day, these adding machine tapes are checked against the cash, the merchandise left, and the inventory charts which each department chairman has made out ahead of time to show the item, number, cost and selling price of everything she had to sell.

Thus, by the time the show is packed up, this four-way check tells fairly accurately how well the show has done financially. Last year, sales were ap-



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proximately $11,000—a big job well done! As Mrs. Roby says, "We're all dead by the end of the day but still happy."

Just what kind of organization is the league itself? It isn't a society women's organization, though it's probably true that none of the members is in the lower class, financially. Most of them say they work harder for the Methodist Hospital Service League and enjoy it more than any other community work they have ever done.

One requisite for membership, as stated in the by-laws, is "willingness to give a generous amount of time in volunteer work to the hospital as approved by the personnel committee."

Besides leisure time, prospective members need some kind of talents or abilities. As a result, though many would like to propose their best friends as members, they don't—without deciding first whether best friends can also be good service leaguers.

By these methods a close, cohesive organization of 106 (at the present time) has been built up. Says Mrs. Blossom: "I think there is a fellowship in the organization because it's not too awfully large." And Mrs. Davis, president, says she feels quality is more important than quantity so there will be plenty of enthusiasm and opportunities for work for each member.

Queried about the league's relationship to the Methodist Hospital's board, Dr. Smith replied: "The league and the hospital's relationship is one of close cooperation. They don't ask the unreasonable—no prima donnas. They're a tremendous asset to the hospital." The hospital board of trustees shapes hospital policy only, however, and leaves its accomplishment up to the executive director. The service league is an entirely autonomous organization.

At last we're getting closer to the "why" of Mrs. Davis' six-word success story—"We're not a lazy woman's organization."

Enthusiasm, efficient business methods, membership picked for quality rather than quantity, a large rotating board assured of fresh ideas from its new members elected each year, a 12 month program which requires every member's efforts to make it successful—these are some of the main ingredients. At least two more can be added.

Number 1: the generals never get too big to be privates.

Number 2: *esprit de corps.* Mrs. R. C. Lee, the league's publicity chairman, gives an eloquent impromptu explanation:

"Some of my friends ask me sometimes, 'Why do you work so hard for the Methodist Hospital? You're just making it a workshop for the doctors.' But I feel it's a civic thing. Our health is most important. We've established a fine hospital here. The objective as stated in the by-laws is very important, I feel.

"'The object shall be to help make the Methodist Hospital a continually better hospital. The Service League's fulfillment of this objective will be basically financial. . . . As volunteer workers in the hospital, it shall be each member's obligation to be well informed about the hospital in order to interpret its work to the community and thereby win public support and confidence for the institution for whose benefit the Service League is organized.'"

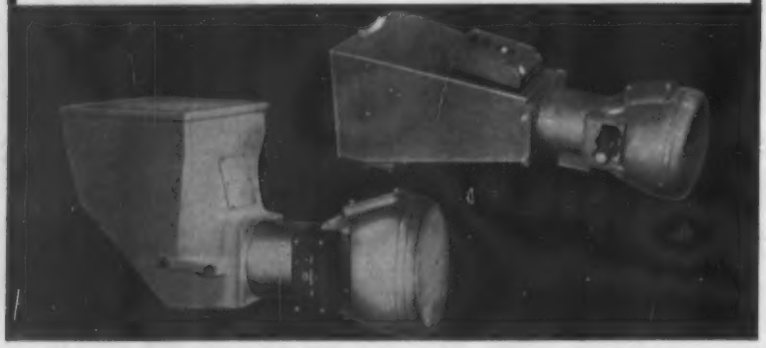
But for once, a man has the last word.

Summarizes Dr. Smith: "I'm frankly amazed at their devotion and enthusiasm. They definitely feel that it is their hospital."

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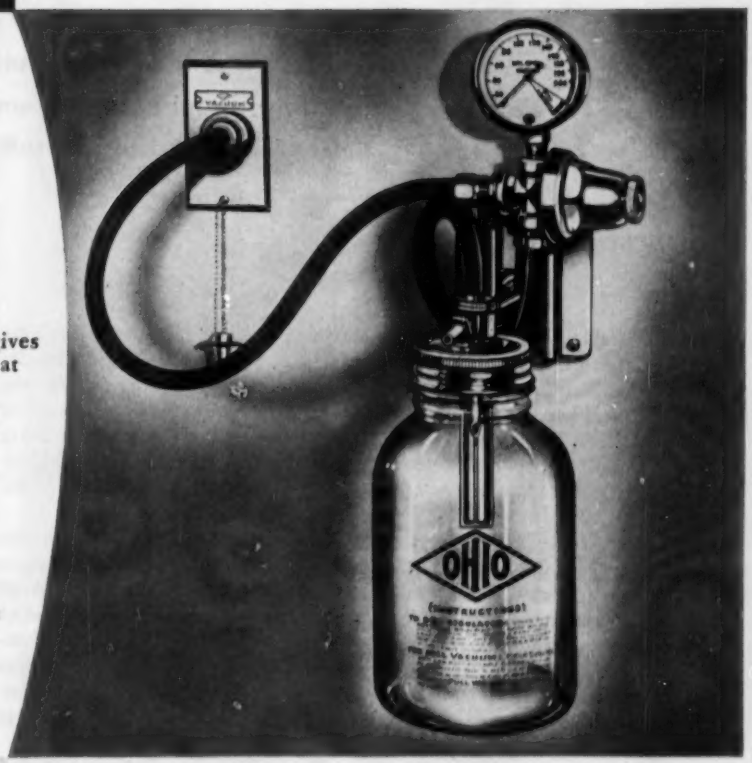
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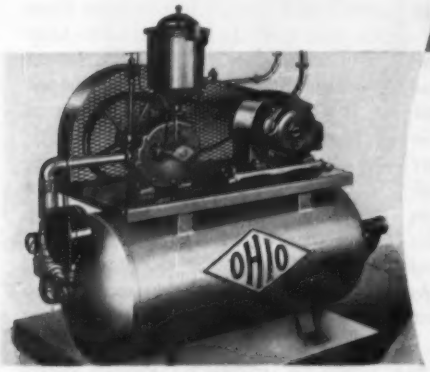
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Organizing an Inhalation Therapy Service

The nine steps outlined here will lead to an efficient, economically sound inhalation therapy unit from which hospital, staff and patients will benefit

DON E. GILBERT

THE advantages and benefits to the patient, the hospital, and the medical profession resulting from a well organized inhalation therapy department under the supervision of a trained therapist have been demonstrated and recorded many times (see bibliography).

Step 1. The first step in the organization of a department is to get in touch with the doctors who are vitally interested in inhalation therapy and form a temporary committee to evaluate the advantages and problems of such a department in the hospital. One of these doctors could and probably would be, eventually, the head of the department and serve as its clinical adviser.

Step 2. Enlist the interest of all department heads and personnel who in the past and present have been responsible for inhalation therapy, *i.e.* nursing department, orderly department, anesthesia, receiving and delivery department, accounting department. From these sources you should be able to gather such vital statistics as: (a) average number of active cases in a given period of time; (b) close approximation of amount of oxygen and other gases used; (c) types, quantity and quality of equipment now in use; (d) approximate cost of various types of treatment; (e) revenue realized from inhalation therapy; (f) how many, what type, and how expensive were repairs for equipment in the past year; (g) what accidents have occurred in connection with inhalation therapy equipment in the past; (h) what national, local or insurance safety codes are not being observed at the present time, and (i) what rooms would be available for the department headquarters.

Step 3. Obtain approval. With the information obtained from the literature on the subject, the findings of the temporary review committee of doctors, and the results of the aforementioned vital statistics, Step 3 is to present this information to the hospital administration for approval to set up the department.

Step 4. Location of the department. The department should be located near the delivery dock or receiving room to minimize the time and expense in the delivery of cylinders and other equipment. It should be kept in mind, however, that it is equally important for the unit to be close to a service elevator so that service is fast and convenient to the patient areas. At least one wall should be an outside one to provide proper ventilation.

Lighting should be considered so that it is adequate for repairs and upkeep of equipment and any book work that will have to be done.

There should be enough floor and wall space and plumbing facilities available for a large, deep, two-bowl sink.

Other physical equipment should include:

1. A workbench and tools for minor repairs and adjustments to therapy apparatus.

2. Desk, chair, filing cabinet and telephone.

3. Storage cabinets or shelves for masks, humidifiers, linen, dressings, oxygen tent canopies, books.

4. Storage racks for pressure regulators.

5. If cylinder oxygen is used there should be space for at least three days' estimated volume.

6. Sufficient space to store large bulky machines such as adult oxygen tents, suction machines, resuscitators, respirators, incubators.

Light switches and electrical outlets should be located 4 feet or more from the floor level. It is also good to keep in mind the fact that cylinders should not be stored near hot steam radiators.

Step 5. On the basis of the list of equipment now in use, and in anticipation of a future increase in the number of active cases, new types of equipment should be ordered to replace that which is obsolete or worn out, or to augment salvage type of equipment. It is best to include also new types of nebulizing, humidifying and pressure breathing equipment.

Step 6. Design all printed record forms so that they coincide in size and placement of information with other similar printed forms now in use in the hospital.

1. The requisition for inhalation therapy service should include all pertinent information so that the technician can set up and initiate the most effective treatment in a minimum of time and on the right patient. This form should have space for the patient's name, registration number,

Mr. Gilbert is chief oxygen therapist, University Hospital, Ann Arbor, Mich.

Presented at the Tri-State Hospital Assembly, Chicago, 1955.

Surgical correction of
NONUNION OF TIBIA



May, 1954. August, 1954. February, 1955.

RADIOGRAPHS: A-P preoperative and postoperative.



COLOR PHOTOGRAPHS: Surgical repair—6 views; this page and page following.

1. Left leg showing adherent scar over tibia. Large pedicle flap graft from opposite leg extends over to fibula.

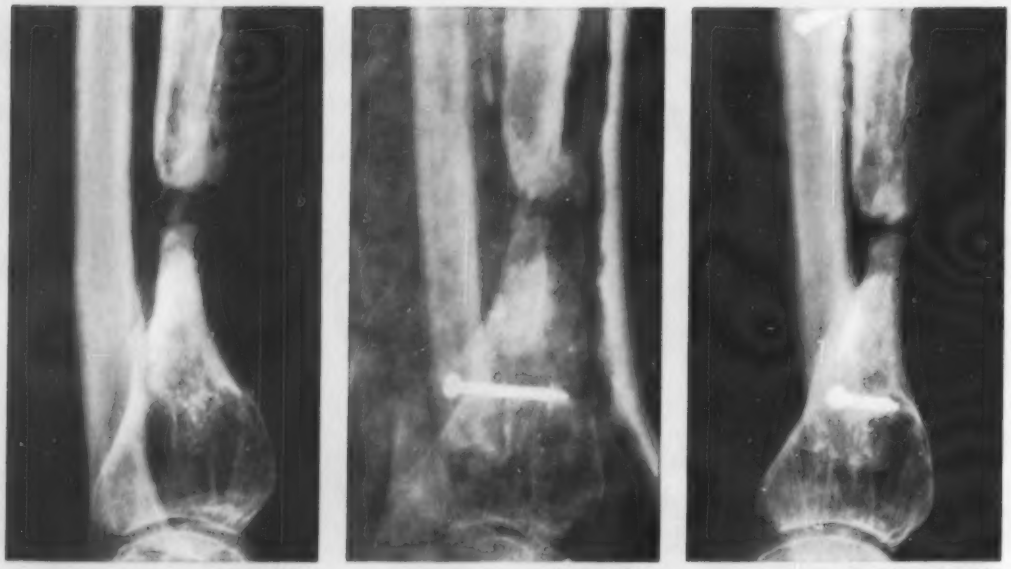
2. Exposed *peroneus longus* muscle and fibula. Scarred extensor muscles being retracted from tibia and fibula.

3. Fibula sectioned about 4 centimeters above *malleolus*, and is being mobilized for insertion into tibia.

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Kodak



May, 1954. August, 1954. February, 1955.

RADIOGRAPHS: Lateral preoperative and postoperative.



COLOR PHOTOGRAPHS: Continued from preceding page.

4. Foot displaced laterally correcting varus. Fibula being fastened into lateral side of tibia.

5. Stainless steel screw holds fibula firmly in cavity. Bone fragments packed in to insure solid healing.

6. Space between fibula and tibia above nonunion packed with autogenous cancellus bone and cortical bank bone.



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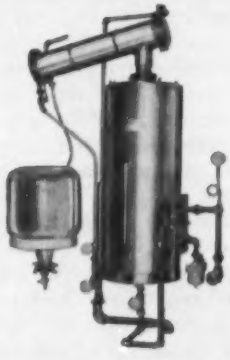
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OXYGEN THERAPY REQUISITION AND CASE RECORD

Service: Medicine Class: 16A Date: 7-20-3 Pm Location: 6P Service: Med

Date & Time Started: 7-20-3Pm Disc: 7-21-8Pm

Type Therapy: Adult tent Std'by ☐

Indication: Coronary thrombosis

Pt.'s condition at Start: Poor

Reg. No. 666001

Name: Doe, John

Address: City

Floor: 6P Room: 432 Sheet #: 1

Pt's condition when discontinued — Improved ☐ No Improvement ☐ R. C. ☐

Signed— Dr.: Jones Nurse: Brown

Above This Line to be Filled in Before Ordering Service

TO BE FILLED IN BY TECHNICIAN ONLY

EQUIPMENT INVENTORY

Regulator # in	out	O₂ tent # in	out	Humidifier # in	out	BLB oro-nasal OEM pos. press. Nebulizer Other N.C.G.	BLB nasal OEM Catheter Canopy-46 Others
109		4-20					

TECHNICIANS DAILY REPORT RECORD

Date & Time	Am't - O₂	Flow	Conc. %	Cath. Chg'd	Remarks	Signed
7-20-3Pm	2xF	12	50		started	[illegible]

Fig. 1. This oxygen therapy requisition and case record form is a combination of three forms: a requisition for service, an equipment inventory, and a daily record sheet for the technicians. The upper third is filled in by the nurse or doctor who orders the service; the inventory and record are filled in by the technicians.

location, diagnosis, type of therapy desired, the patient's condition at the start of treatment and at the time treatment is discontinued, and a place for the signature of the doctor and nurse.

2. The a.m. equipment inventory form should record the equipment in use and where.

3. A daily record form for technicians should include space for the date and time the patient and equipment were checked; the pressure or amount of gas remaining in the cylinder; the rate of flow; concentration per cent in tents, incubators and hoods; the time when the catheters were changed; a remarks column for recording when the patient was charged, changes in patient status, and so on, and a space for the technician's signature.

At the University of Michigan Hospital, Ann Arbor, these three forms are included in one form which is called the oxygen therapy requisition and case record form (see Fig. 1). The upper third is filled in by nurse or doctor ordering the service. The inventory and daily record are filled in by the technicians. The original is kept on the floor; the duplicate by the inhalation therapy department.

4. The charge ticket (Fig. 2) should have space for the patient's name, registration number, classification, address, date, time, type of equipment used, and the amount of charges. This ticket is filled out by the head therapist and sent to the accounting office daily for processing.

5. Forms for compiling vital statistics should give at a glance any kind of information needed regarding the functions of the department in checking its efficiency and economy. From it one should be able to determine the following points:

a. If charges to the patients are covering the cost of the service, and equally important, whether or not patients are being overcharged.

b. Is the department overstaffed or is there reason for believing that additional help is indicated?

c. In case the hospital may be considering an eventual "bulk storage" or piping of oxygen to some of the areas, the statistics sheet will show which area has the greatest volume. (*Cont. on Page* 100)

OXYGEN THERAPY CHARGE TICKET Nº 504050

CHECK (X) ONE: IN PT. ✓ OUT PT.

AUTH. BY: [illegible] DATE: 7-21-55 LOCATION: 6P SERVICE: Med

HELIUM-OXYGEN
TANK FULL ☐
¾ ☐ ½ ☐ ¼ ☐
CATHETER ☐
TENT ✓
MASK ☐
INCUBATOR ☐
NEBULIZER ☐
STANDBY ☐

REG. NO. 666 001
NAME Doe, John
ADDRESS City

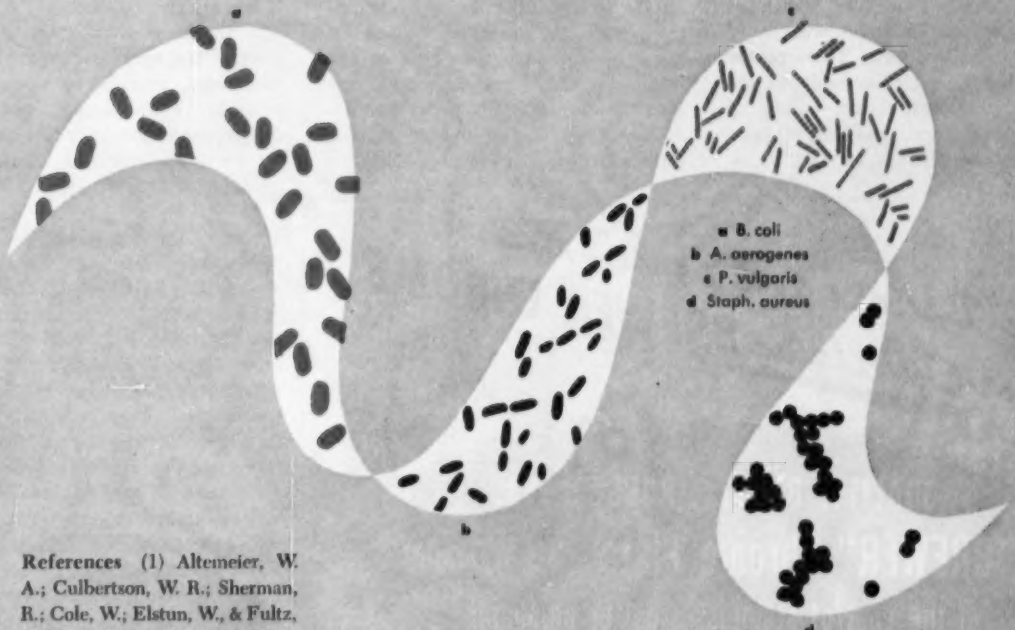
SERVICE
FROM DATE 7-20 TIME 3 A. M. P. M.
TO DATE 7-21 TIME 8 A. M. P. M.
TOTAL HRS. 5 DAYS 1

CLASS	REV. #	AMOUNT
16A	336	~~##~~ ~~##~~

UNIVERSITY OF MICHIGAN — UNIVERSITY HOSPITAL

Fig. 2. The charge ticket is filled out by the head therapist who records the necessary data and then sends the form to the accounting office daily.

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Step 7. Personnel. The actual working head of the department is, of course, a member of the American Association of Inhalation Therapists or one who has had similar training and experience in inhalation therapy. If the hospital is large and will require 24 hour, seven-day service, it will be necessary to hire additional technicians to work nights, week ends, vacations and sick time. These people should be trained thoroughly in the physiology of respiration, theory of inhalation therapy, and safety practices before they are allowed to assume the responsibility of administering therapy to a patient.

Step 8. Determine the charges for service to the patient. At this point again the accounting department can be of great help. The estimated costs should be figured on the various types of anticipated services, *i.e.* the depreciation of expensive types of equipment and the estimated volume of expendable or "one-time" use of any material (rubber masks, nasal catheters, cleaning materials, paper towels). Although the cost of oxygen itself is minimal in the over-all picture, it should not be disregarded completely. One of the largest items is the labor of setting up, checking, cleaning, servicing, repairing and storing the equipment.

Enough of a margin should be charged to prevent the service from costing more than the revenue that is taken in.

A simple way to charge is on the basis of the time and type of equipment used, prorated to be as fair as possible. For example, one would charge more for an adult tent than for an infant tent and less for eight hours of service than for a complete day.

Step 9. Make certain that all departments are aware of how the service will be handled. This can be done by a front office directive to all nursing units and staff members, a report at staff meetings on how the department functions, or a notice in the hospital paper or bulletin.

When all these steps have been taken, the department will be off to a good start. It will be ideally located, well equipped, the charging system will be economically sound, and well trained therapists will be available to carry out its functions. However, to maintain this high degree of service will require constant checking to see that the equipment is operating at its most effective and safest level. New and better equipment and methods of administration will be found. To keep abreast of these advances, a membership in an organization founded for these purposes would be highly desirable. The better hospital and medical publications should be read routinely and the status of costs and charges should be reviewed to see that they are fair and equitable. Improving and augmenting the functions of the department constantly should be kept in mind with consideration given first to the patient and then to the hospital and the medical staff.

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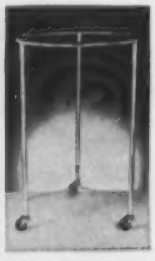
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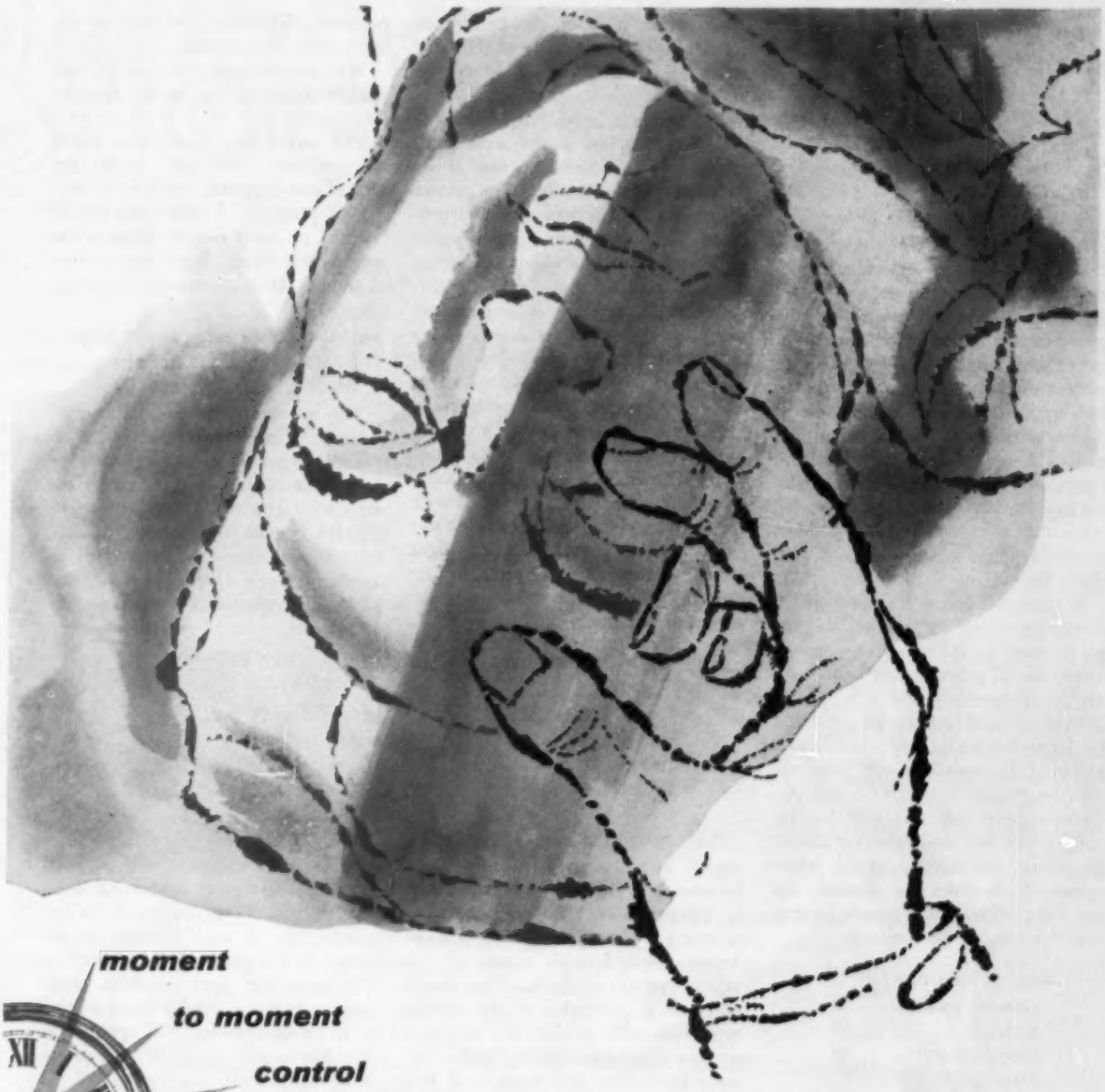
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Surgical Prep Shave

(*Continued From Page* 83)

b. Do you use—

Individual trays	56
Prep cart	23
Prep basket	13
Other (a tray on nursing unit)	12

Analysis indicates that the trend is toward the use of individual prep trays. Technically, this is good practice as a means of controlling the spread of harmful bacteria. The equipment should be clean, but sterile equipment is unnecessary; we are concerned with terminal sterilization only (sterilization after use). The large hospital with a long operative schedule and equipped with anesthesia rooms, where we feel the prep should be done, can use a tray with a simple setup. Most of the supplies can be stocked routinely in the room.

If anesthesia rooms are not included in the operating room suite, and the preps must be done in the patient's room, an all-purpose cart containing the stock materials and a supply of individual trays should be provided. In large hospitals, two carts would probably be necessary, one for the operating room orderly who will perform male preps, and one for the nurse's aide who will perform female preps. In the small hospital, where operative schedules are limited, one cart for both male and female patients would no doubt be sufficient.

c. Kind of light provided:

General room	38
Spotlight	25
Extension light	34
Flashlight	25
Patient's bedside light	40

There is a wide variety in the type of light used. Furthermore, it is one of the chief complaints as far as equipment is concerned. General room lighting in the form of a ceiling light or wall type is certainly insufficient and has to be supplemented in some way. A spotlight provides good light but is an awkward piece of equipment to handle, even if the design includes good casters. An extension light can provide good lighting but presents a problem unless there is a way to attach the light fixture firmly to a support. To place an extension light on the patient's bed as is so often done is hazardous and invites accidents. A flashlight is far less hazardous, but inasmuch as it is of the battery or dry-cell type, the intensity of the light varies considerably. Often, it will be insufficient.

The patient's bedside light, according to the survey, is the most commonly used, no doubt because of its convenience in location. The newer design, which is a floor type and provided with a reflector, serves quite well. However, the older type, often mounted on the wall above the patient's bed, is certainly inadequate and should not be considered.

If the prep is performed in an anesthesia room (in OR suite) as recommended, regular operating room lighting is sufficient. When the prep must be done in the patient's room, we recommend the use of a spotlight, securely mounted on a prep cart with an adjustable head so the position can be changed to provide sufficient light for the various operative areas, to prevent accidents, and to solve the transportation problem.

d. Type of razor used:

Straight	15
Regular safety	72
Special safety	17
Electric razor	3
Razor blade on a hemostat	1

The most frequently used is the regular safety razor. This is no doubt because it is thought to be the safest in inexperienced hands and the most economical from the standpoint of initial cost. Special razors of the safety type are available. The design of these is preferable to the regular type inasmuch as they are available in two sizes—one which carries a 2 inch blade for flat areas, and one which carries a 1 inch blade for use in smaller or irregular areas. Both patterns consist of one piece other than the blade and are made of metal, adaptable to satisfactory terminal sterilization.

The straight razor in the hands of a proficient operator is the least time consuming since waste is so easily removed from the blade. The design used by professional barbers but made of metal which can be easily sterilized is available. These razors are provided with a removable blade, identical to the safety razor blade. They are also available with a guard to be used whenever necessary.

Electric razors are safe, but do not shave as closely as the safety or straight razor and present a sterilizing problem. Therefore, we do not believe they are practical.

We recommend the use of the straight razor or the special type of safety razor.

The survey also shows that razors are sterilized (terminal) in 80 per cent of the hospitals. Technically, this is good practice. A clean razor should be used on each case to prevent the spread of bacteria from one patient to another. Heat sterilization is recommended.

e. Do you do a dry or wet prep?

Dry	10
Wet	99

The wet prep is used in the great majority of cases. Exceptions were indicated in some emergency cases or for certain operations specified by the surgeon. The wet prep is recommended because it makes for a more efficient and thorough shave, aids in controlling the spread of hair and waste, and minimizes the discomfort to patients.

Lather is provided by:

Soap	68
Detergent	30

Applied with:

Shaving brush	2
Gauze sponge	75
Cotton ball	27

The agent used to provide lather seems to be a matter of choice. Both soaps and detergents containing G-11 are available. The detergents are expensive, but if used sparingly as directed do not present a cost problem. The large size cotton ball is much more economical than the sponge and is recommended for the application of either soap or detergent. List prices as of April 1954 were: cotton filled sponge 4 by 4 inch, $0.0125; all gauze sponge 4 by 4 inch, $0.0130; large cotton ball, $0.0020.

f. Provision for waste:

Jar	2
Paper bag	47
Wastebasket	11
Emesis basin	34
Paper towel	6
Newspaper	5

The waterproof paper bag is recommended as a means of waste disposal. It restricts the spread of refuse, and eliminates the cleaning of receptacles after use since the bag and its contents are discarded.

g. Are rubber gloves used?

All cases	8

(*Continued on Page* 104)

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- fewer unwanted effects

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*T.M.

MS-J-55

No cases 20
Contaminated cases ..58
Specific area cases 27

Rubber gloves should be used by the operator in all contaminated cases and in specific area cases such as rectal and perineal preps which are potentially dirty cases. The use of gloves aids in controlling the spread of infection from one patient to another and also safeguards personnel.

First quality gloves are not necessary. After use, they should be handled the same as any contaminated material, *i.e.* terminal sterilization using heat as the agent. A paper bag again provides satisfactory protection during transportation.

9. Do you consider the surgical preps in your hospital to be:

Very good 18
Good 39
Satisfactory 33
Unsatisfactory 9

(See General Conclusions)

10. Please list any suggestions which might improve this function.

Forty-eight hospitals made suggestions for improving the surgical prep. Summarized, these suggestions were as follows:

12 suggested that the responsibility of this function should be delegated to the operating room.

13 suggested that the responsibility should be delegated to as few persons as possible, and that they should be carefully selected and trained nonprofessional personnel.

10 suggested that better equipment should be provided, especially lights and razors.

13 suggested miscellaneous improvements such as:

The prep order should be left at time operation is scheduled.

There should be closer instruction and follow-up.

Special room should be provided to do preps.

A male nurse should do male preps.

Preps should be performed on the day of operation.

The use of charts to show prep areas would be helpful.

SUMMARY

This study has suggested the kinds of improvements that can be made in this procedure. The response to the survey questionnaires, with 76.3 per cent return, clearly indicates the interest in and the need for constructive attention to this procedure.

Available funds and time have not permitted as extensive a study as is desirable. For example, it would have been profitable to have followed through with the proposed design of the prep cart by arranging for the construction of a sample and its trial use in one of the hospitals.

Another phase of the study which developed near the end of this year's work was consideration of a new technic for the preliminary preparation of the operative area. This technic involves the use of a depilatory or surgical hair removing cream. Our preliminary investigation of such a product indicated its potential value for use in the prep procedure.

The successful use of this type of product in preoperative preparation would have the advantages of simplifying the procedure, minimize discomfort to patients, reduce time required, and eliminate the need for so much of the equipment now used in this procedure.

Funds need to be made available so that further study and experimentation can be carried on.



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A Synopsis of Biological Assay

"When you can measure what you are speaking about, and express it in numbers, you know something about it; but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind; it may be the beginning of knowledge, but you have scarcely, in your thoughts, advanced to the stage of science."—LORD KELVIN.

THE determination of the potency of a drug by means of a response of a biological system is called a biological assay. Such an assay is necessary for those drugs of which the exact nature, constitution or potency cannot be measured by physical means. Sometimes this happens because we lack methods for determination, when the chemistry of a drug is unknown, and the drug indicates its presence only by its biological activity; sometimes, because our existing physical or chemical methods are not sensitive enough or do not discriminate quantitatively between mixtures of active ingredients. We encounter drugs in therapy in the form of impure mixtures or solutions, containing different amounts of various active constituents. We are dealing in research, particularly in endocrinology, with organ extracts containing unknown active constituents. The third situation arises in research on new chemically pure drugs when we wish to compare their potency to that of our established similar drug. In all three problems of assay, the main point is that we want to determine the potency of drugs.

REFERENCE STANDARD

The biological system used for such a determination of potency may vary from an intact animal, an isolated organ, isolated tissue, or bacteria to material derived from biological sources, for instance, enzymes. A certain dose of the drug induces, on application, a certain response in the biological system. The response is measured and the numerical value of the quantity of response represents a measure of the potency of the drug. Expression of the potency of the drug in the numerical value of a response standard will enable us to standardize and interrelate our values of potency.

A biological system shows a great variability in its response to fixed stimuli. This variability, apparently inherent to living matter, occurs in the same individual at different times ("dynamic variation") as well as from individual to individual ("static variation"). This instability in sensitivity to stimuli of the same potency will impair the accuracy of measurement. It may be tempting to express biological potency in a standard of biological response as, for instance, in the death or cure of an animal, but the expression of potency in such a variable standard is inaccurate and unjustified. Expression of the potency of our drug in a fixed invariable standard is necessary.

This is the same basic principle which applies to all physical measurement by fixed reference standards of length, weight and time. In biological assay this is obtained by comparing the potency of our unknown stimulus, the drug, with the potency of a fixed amount of a reference standard. The potency is expressed as the amount of the standard preparation giving an equal response. The use of a stable, generally agreed upon reference standard allows us to standardize and interrelate our values of biological potency.

The importance of accurate determination of the potency of therapeutic agents can easily be seen in the case of insulin, where over or under dosage outside very narrow limits manifests itself by very unpleasant symptoms of hypoglycemia or hyperglycemia. When the variability in the potency of drugs is eliminated, we still have to face the fact that these drugs are used on biological systems, patients or animals, each with their own variability.

WORK OF EHRLICH AND MAGNUS

These problems of biological assay were early encountered, recognized and studied by two investigators. Ehrlich in his work on diphtheria antitoxin needed an indication of the potency of his preparations. He devised the minimal lethal dose (m.l.d.) of diphtheria toxin for a 250 gram guinea pig and measured antitoxin in terms of potency to neutralize 100 m.l.d. of toxin.

However, Ehrlich's standard of diphtheria toxin was unstable and toxins prepared at different times showed different potency. This unstable standard made interrelation of various data of antitoxin potency impossible. Ehrlich eliminated this difficulty by replacing his unstable standard of toxin by a stable standard, the activity of the weight of a preparation of dried antitoxin. He then compared at the same time in different guinea pigs the potency of his unknown antitoxin with his stable standard antitoxin, using the same preparation of toxin. In this way he eliminated the variability of his toxins, and by using a group of guinea pigs as homogeneous as possible, he avoided the problems of "static" biological variation.

The unsatisfactory condition of expressing the potency of digitalis preparations in frog units and cat units led Magnus in 1923 to propose the establishment of a unit of potency, expressed in the weight of a standard preparation of digitalis leaf. In determining the potency of this standard preparation the importance of animal variation for the expression of potency

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was realized by the investigators at Magnus' laboratories at Utrecht. They conducted a biological assay of digitalis by determining the threshold dose of digitalis required to cause cardiac arrest in a lightly etherized cat by intravenous infusion under certain conditions. The frequency at which the various minimum lethal doses appeared in their experiments on 573 cats was distributed over a wide range of doses. The frequency became zero at values deviating 50 per cent from the mean lethal dose. This observation led to the realization that a direct estimation of potency in animals by means of the m.l.d. had little significance.

TREVAN AND THE LD.50

Trevan determined, in an indirect way, the minimum lethal dose of digitalis on Rana temporaria. He injected stepwise increasing doses of digitalis into groups of frogs and recorded the percentage that died at each dose level. He plotted these death rates against the logarithm of the dose and obtained a sigmoid curve. This curve was flat at its lower end in the region of the 0 per cent and flat at its upper end in the region of the 100 per cent response, but was steep in the region of the 50 per cent response. Surprising was the wide gap between the dose which failed to kill any animal and the dose just great enough to kill every animal. This emphasized the quantitative imprecision of the m.l.d. as endpoint. Trevan proposed that the dose which killed 50 per cent of the animals was perhaps a better endpoint, as the steeper slope indicated that relatively more animals react in this 50 per cent range than in any other range. He called this endpoint the LD.50. He showed that the position and the steepness of the slope varied with the lethal agent and with the species of the animal tested. The form of the slope thus gave indications about the variability of the biological system.

POTENCY RATIO

The greatest step forward came from the observations made when different investigators were asked to compare two preparations with each other. Although their findings did not agree on the absolute potency of the drugs, they usually agreed very well upon the ratio of potency of the two preparations in spite of their using different animals and methods which were dissimilar in important details.

Their findings strongly emphasized the use of a reference standard. If the standard was introduced as one of the preparations, then the absolute potency of the other, the unknown preparation, could be expressed by use of the potency ratio, in a fixed amount of a reference standard. The rôle of the biological variability had now only to be considered in the estimation of this potency ratio. By comparing simultaneously the potency of unknown and standard preparations on the same biological system at the same occasion, the effect of the variability in sensitivity is much diminished. This will greatly increase the accuracy of the estimation of the potency ratio, and by this the accuracy of the assay. The second case is the approach which assumes that in groups of individuals this variability in sensitivity is equally distributed. By comparing the responses to standard and unknown in random samples of the population of test objects, we can compute the potency ratio and its standard error from the individual values of the two series of observations. After determination of the fiducial limits of this ratio, we are able to give an estimate of potency within certain limits at a certain level of probability.

In all biological assays it is necessary that the drug constitutes an appropriate stimulus to the biological system. The quantity of the response must show relationship to the dose of the drug. The response may be a quantitative measurement, such as a rise in blood pressure or the height of a muscular contraction. In this case it is called a graded response. It may be an all or none response such as the occurrence or nonoccurrence of an event like a convulsion or death. These are called quantal responses.

In summary, a biological system can be used in order to compare the potency of two drugs. A biological system cannot be used by itself to define the potency of one drug preparation alone. No assay can be considered valid unless it measures potency in terms of a reference standard preparation.

In spite of the long history of biological assay, new assays of biological activity are not always designed with the historical lessons in mind. Many of them go through the same stages as the diphtheria antitoxin and digitalis assay. Especially in the research on new therapeutic substances, as well in pharmacology as in endocrinology, we will encounter the tendency to express potency in variable animal units. The use of mouse units or pigeon units should not be advocated, even as a preliminary research tool. The recent temporary appearance of a "rabbit headdrop unit" for tubocurarine causes one to wonder why the "giraffe unit" is not suggested; in this species a 50 per cent headdrop would certainly give a more easily observable endpoint.

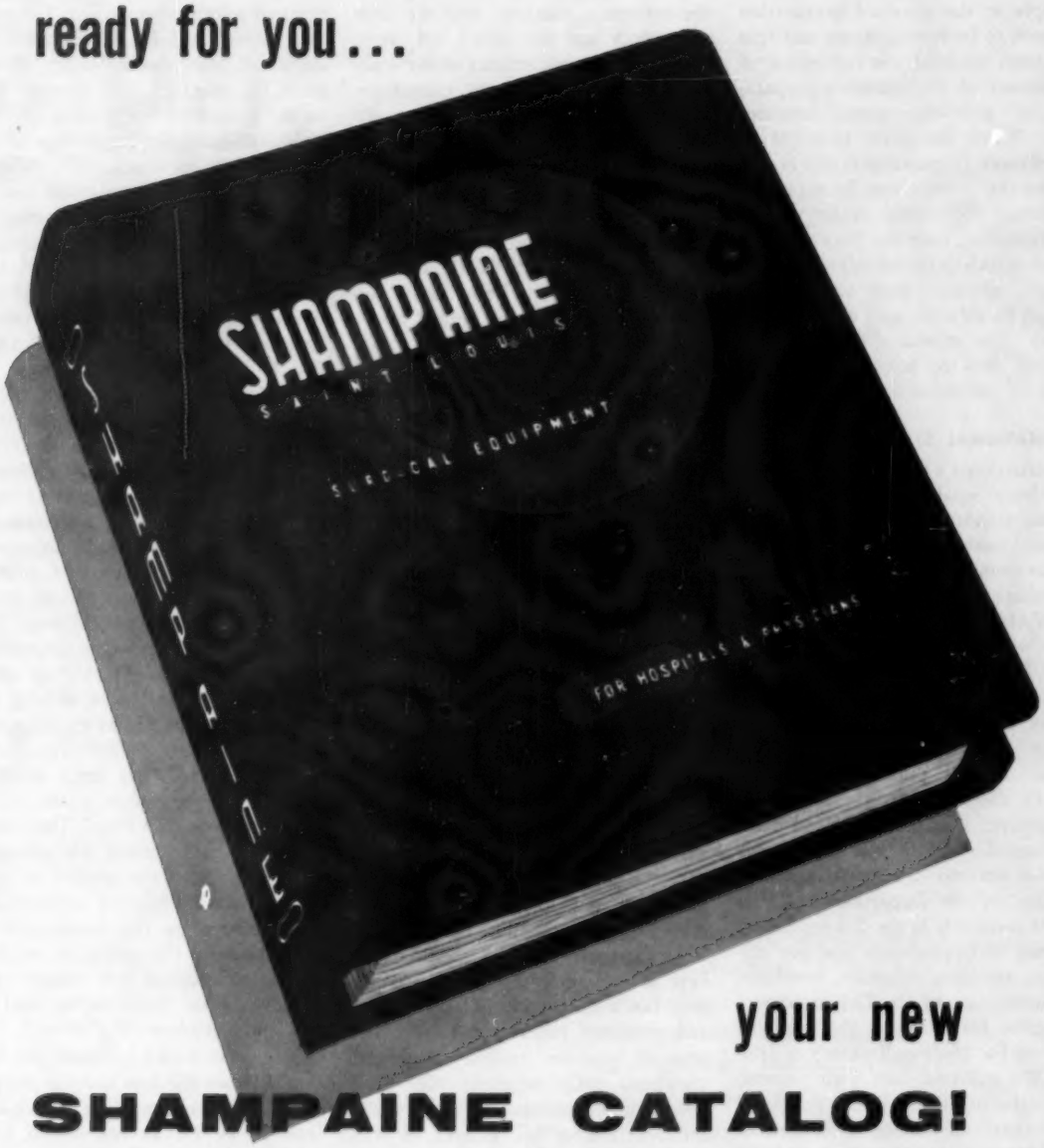
STANDARDS AND UNITS

In adoption of a preparation as reference standard the material should satisfy the following conditions: (1) The standard preparation is stable. (2) The biological active substance in the standard is homogeneous. (3) The active substance in the standard is the same as the unknown substance to be assayed. This is done to satisfy the condition that the substances to be measured should have the same site and mode of action. This makes parallel testing possible over a wide range of doses given at different time intervals. Recent studies into the kinetics of drug receptor interactions have shown that drugs of apparently the same site and mode of action can show different potencies on the basis of different kinetic behavior with their receptors. This condition is open to further study. In preliminary pharmacological research for new drugs this condition is often neglected. (4) The standard preparation is as pure as possible. If impurities are present, they should not have a specific activity resembling that of the active principle, nor enhance or antagonize the behavior of the active principle. (5) The response of the biological system to the standard is due to the active principle it is desired to measure. (6) The ratio of the potency of standard and test preparation is independent of the biological system used. (7) The biological effect measured need not have relation to the desired effect in man, although in the first instance this may seem of great interest.

It must be admitted that some official biological assays with reference standards do not fulfill all of these conditions. The consequences of such deviations are sometimes not too serious and the assay will serve as a useful tool.

If the reference standard is heterogeneous, a unit of substance is defined as a stated amount, weight or volume of the reference standard. The potency

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of the unknown preparation is expressed in units. When the active principle in the standard preparation is known to be homogeneous and free from inert material, the expression of the potency of the unknown preparation in gram-equivalents becomes valid. When the active principle of the unknown preparation is also homogeneous the potency may be expressed in grams. We would prefer to call standardization only the pure physical process which involves adjustment of strength of the drug to standard strength by dilution with an inert substance. The correct dilution is carried out with the help of figures obtained by biological assay.

INTERNATIONAL STANDARDIZATION

International reference standards have been established. These international standards are provided to the national health organizations of the various countries by the World Health Organization. The executive board of the W.H.O. has established an expert committee on biological standardization. This committee advises the executive board and submits scientific reports on biological standardization to the executive board for publication. In the publications of the W.H.O. the standards are divided in two groups: immunological and pharmacological. The international standards for antitoxins, antigens and sera are kept by the Department of Biological Standards at the Statens Serum Institute at Copenhagen and for glycosides, alkaloids, vitamins, hormones and antibiotics, by the Department of Biological Standards at the National Institute for Medical Research at London. We will deal only with pharmacological standards and assay problems.

All national health organizations have adopted the international reference standards. These national health organizations provide equivalent national substandards, which are available to interested organizations, such as research laboratories and drug manufacturers. In the U.S.A. the national pharmacological standards are made available by the United States Pharmacopeia Committee, by the Food and Drug Administration (antibiotic reference standards) and by the American Pharmaceutical Association (National Formulary Reference Standards).

ASSAYS, METHODS AND STANDARDS

Following are examples of biological assays which are in general use. The drug assayed, the pharmacological response on which the assay depends, the reference standard, and the unit of potency are mentioned. Of three of them, the characteristics of the assay and the methods of potency calculation are discussed. The three assays are examples of the three main types of assays. Knowledge of these examples, their historical development, and some of their important details is very useful in understanding and designing other assays. No assay is exactly like another. Unless otherwise indicated, the data are taken from the United States Pharmacopeia XV.

1. *Powdered Digitalis.* Cardiac arrest in the pigeon. U.S.P. Digitalis Ref. Standard. One U.S.P. digitalis unit equals 100 mgm. of the U.S.P. Digitalis Ref. Standard. This assay is based on all or none response, with a direct estimation of the threshold dose for the response. Groups of at least six pigeons must be employed for the standard preparation and for the preparation to be assayed. Pigeons should be adults, which are not emaciated or grossly diseased. They should be of sufficiently uniform size so that the heaviest is less than twice the weight of the lightest. Food, but not water, is withheld for 16 to 28 hours prior to assay. The pigeon is lightly anesthesized with ether and immobilized. An alar vein is exposed and a canula is inserted. The canula is connected to a small-bore calibrated burette containing the diluted preparation. It is important that the anesthesia be kept at such a level that pain is absent, but with retention of the corneal and pupillary reflexes, and some degree of muscular tension. A deeper anesthesia may augment the toxic effects of the preparation and thereby influence the results. One cc. of dilution per kgm. pigeon is rapidly injected, and this dose is repeated at 5 minute intervals until the bird dies of cardiac arrest. This is determined by counting the heart rate just before each new dose.

The average number of doses of each preparation necessary to produce death must be between 13 and 19 and the smallest number of doses shall not differ by more than four doses from the largest number of doses. This is done in order to ensure fairly equal injection rates of both standard and unknown. It has been shown that higher threshold doses are obtained by rapid injection than by slow injection. If these conditions are not fulfilled, the data are regarded as preliminary and the assay is repeated, an adjusted solution being used. The relative potency and its precision can be calculated from the difference of the mean log doses of both groups. The standard error of the relative potency is found from the logarithms of all individual lethal doses. The fiducial limits to the relative potency can be determined at $P=0.05$. Evaluation of the antilogarithms gives assurance at a 95 per cent probability level that the true value is between these fiducial limits. The fiducial limits in the official assay may not exceed 0.30 U.S.P. Digitalis Unit.

2. *Mouse Assay of Insulin.* Production of hypoglycemic convulsions at an environmental temperature of 32°C. Local substandard of U.S.P. Ref. Standard. The assay is based on all or none response. An indirect determination of the dose response relationship is made from the percentage of positive reactions in separate subgroups, tested with different doses of the drug. The endpoint in the assay, the appearance of convulsions, is not easy to determine. It may be either a fully developed convulsion or as the definition says "the mouse is stiff with limbs outstretched and tail erect or it is collapsed so that when placed on its back it cannot turn over." This leaves too much opportunity for disagreement and makes the number of positive responses subjective to individual interpretation by the investigator. A final check on the nature of the convulsion is made, as it is required that the convulsion must be relieved by the administration of glucose.

The curve which indicates the relation between log dose and the percentage of animals responding at each dose level is, as Trevan has shown, of a sigmoid nature. We have seen that the position and slope of this curve are liable to variation. In order to obtain an accurate determination of the point that indicates the 50 per cent response, many points on the curve are required if it is to be drawn accurately. This requires many animals and much time and labor. This can be avoided if we are able to transform our data of dose and response in values whose relationship can be plotted as a straight line. A straight line is fully determined by two points. The percentage of response at two dose levels would then determine our line, and with it the dose for a 50 per cent response. This can be accomplished

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if the data of percentage of response are transformed into data of deviations of the LD.50. (Probit method, Gaddum, Bliss.) The data of dose expressed in log dose plotted against the equivalent of the percentage responses expressed in deviation of the LD.50 give a perfectly straight line. An estimation of potency can be read from our graph.

3. *Insulin Injection.* Lowering blood sugar in the rabbit. U.S.P. Zinc-Insulin Crystals Ref. Standard. One U.S.P. insulin unit equals the potency of 1/22 mgm. of the Ref. Standard. This is an example of an assay based on a graded response. In the rabbit insulin assay each animal can be used more than once. The response on any occasion is independent of previous response. A cross-over technic with two doses, one twice as large as the other, is employed. Two groups of six rabbits that are used on one day are tested again another day. Both groups are injected with the unknown as well as with the standard preparation, but a high dose of one preparation is followed by a low dose of the other and vice versa. This procedure eliminates largely the variation in sensitivity between animals.

Healthy rabbits, weighing at least 1.8 kgm., are used. They are kept under standard conditions, fasted before the assay, and handled with care to avoid undue excitement. Blood sugar is determined from blood samples taken from a marginal ear vein. The response of drug in blood sugar is adjusted by a correction factor for the initial value of the blood sugar. The potency is estimated from the log potency ratio of the four corrected response values of standard and unknown.

4. *Tubocurarine Chloride Injection.* Headdrop in the rabbit due to paralysis of neck muscles. U.S.P. Tubocurarine Ref. Standard. One cc. of tubocurarine chloride injection represents the potency equivalent to the potency stated on the label in milligrams of U.S.P. Tubocurarine Chloride Ref. Standard. This, too, is an assay based on an all or none response with direct estimation of the threshold dose. The general principles are the same as in the digitalis assay, except that here a cross-over technic is used.

5. *Posterior Pituitary Injection.* Lowering of blood pressure in the chicken. U.S.P. Posterior Pituitary Ref. Standard. One cc. of posterior pituitary injection represents an activity equivalent to not less than 8.5 and not more than 12 U.S.P. Posterior Pituitary Units.

6. *Epinephrine Solution.* Increase in blood pressure of the dog. U.S.P. Epinephrine Bitartrate Ref. Standard. Epinephrine Sol. has a potency equivalent to a solution containing 1 gram of epinephrine ref. standard in 1000 cc. Data are taken from U.S.P. XII. In U.S.P. XV epinephrine is measured by chemical methods. This assay is now called the "pressor substance test."

7. *Racemic Calcium Pantothenate.* Growth of Lactobacillus plantarum in a special medium. Turbidimetric method. U.S.P. Calcium Pantothenate Ref. Standard. Potency is given in mgm. of U.S.P. Calcium Pantothenate Ref. Standard.

8. *Vitamin B_{12} Activity.* Growth of Lactobacillus leichmannii in special culture medium. Turbidimetric method. U.S.P. Cyanocobalamin Solution Ref. Standard. One U.S.P. unit of oral vitamin B_{12} activity is equivalent to that of 15 micrograms of U.S.P. Cyanocobalamin Ref. Standard.

9. *Synthetic Oleovitamin D.* Rat Line Test; calcification of bone at the diaphyseal-epiphyseal junction of the tibia or radius in the growing rat while on a rachitogenic diet. U.S.P. Vitamin D Ref. Standard (Pure Vit. D_3). One U.S.P. unit of vitamin D represents the activity of 0.025 microgram per Vit. D_3.

10. *Benzathine Penicillin G.* Inhibition of growth of Macrococcus pyogenes var. aureus. Cylinder-plate method. U.S.P. Penicillin G. Sodium Ref. Standard. One unit of penicillin activity represents the activity contained in 0.6 microgram of U.S.P. Penicillin G. Ref. Standard.

11. *Heparin Sodium.* Prevention of clotting citrated sheep plasma after addition of excess $CaCl_2$. U.S.P. Heparin Sodium Ref. Standard. One mgm. of heparin sodium has a potency of not less than 110 U.S.P. heparin sodium units.

In this list of assays are not included two assays in the pharmacopeia which still make use of animal response as a standard of potency. These assays are the parathyroid assay and the pyrogen test. The biological assays of ACTH injection, adrenal cortex injection, and the depressor substances test are here only mentioned by name.

EXPERIMENTAL DESIGN

Much depends on the design of an assay. Good designs save time and give accurate and reliable results with the smallest possible number of animals. Good designs require, in the first place, simple experimental technics and simple calculations. Doses should be few. If a suitable transformation can be found then two doses, a high and a low one, will be sufficient. Each test should be self-contained and its error should be estimated from internal evidence.

The relationship between dose and response in assays based on a graded response can, within a certain range, take two forms: (1) a linear dependence of response on dose, (2) a linear dependence of the response on log dose. In the first case we speak of a slope ratio assay; the regression lines intersect at the zero dose level. In the second case the regression lines run parallel.

In such a parallel line assay it is generally best to allot doses in geometric series, so that there is a constant interval between the logarithms. In slope ratio assay the doses are generally allotted in an ordinary arithmetic series. Both assays require at least two doses of the standard and one dose of the unknown preparation. For a routine assay this may be sufficient. In a new assay we have to test the validity of our assumptions, first, linearity of regression and, second, intersection at the zero dose level or parallelism of the regression lines. This requires in both types of assay at least six dose levels.

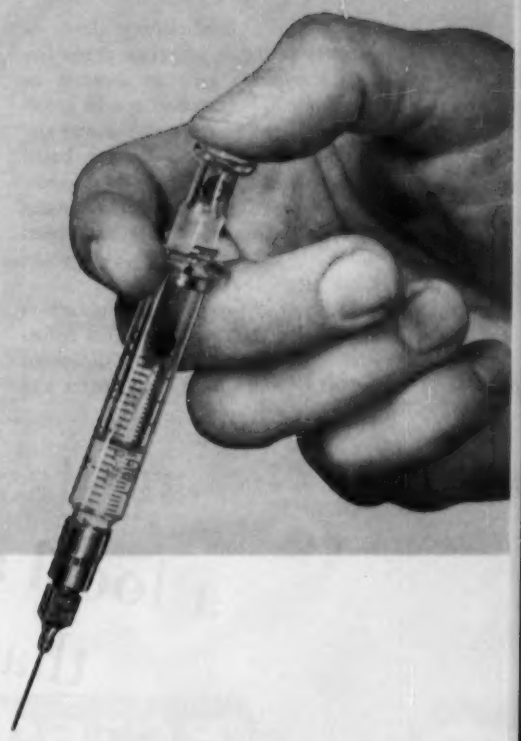
For the response, we have to test the assumptions of the normality of their distribution to a fixed dose and the absence of correlation between the standard deviation of the responses and their mean at various dose levels.

If all these conditions are fulfilled, approximate estimates of relative potency can be made from the graphs of the dose response curves by measuring the ratio of the regression coefficients for the slope-ratio assay or the distance between the lines for the parallel line assay.

INCREASE IN SENSITIVITY, PRECISION

Increase in precision of the assay has to be distinguished from increase in sensitivity of the biological system. An increase in sensitivity may be quite independent from an increase in precision of the assay. Increase in sensitivity makes it possible to measure lower doses of our unknown preparation. This is commonly used in hormonal research. Inanition, pretreat-

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ment with a conditioning dose, or removal of the appropriate organ has been shown to give an increase in sensitivity in hormone assays. In growing immature animals an optimal age for the sensitivity of an assay based on a growth response can be selected. This is not true for the digitalis assay in cats. Kittens and cats have been shown to possess an equal average sensitivity.

Increase in precision is a reduction of the error of the assay. This reduction is obtained by the use of inbred strains of animals or litter mates and by limiting the differences in sex and age. Reduction of the error of the assay permits results of equal precision with fewer animals.

Other sources of error have to be balanced in the analysis of the assay. The individual's contribution to the error can be balanced by using a cross-over technic with two different doses, as in the rabbit assay of insulin. In the graded response the problem of correlation of the value of the response with the initial value has to be considered. If correction for the initial value is made, the correction factor should not by itself be a function of the dose of the drug. One should be very careful in using rejection of so-called "aberrant" animals or doses to increase precision of the assay. This may be justified only when it can be shown from previous observations that this great variation is not due to chance alone.

Past experience with a particular assay, knowledge about the slope of the curve, of the standard error and of the range of linearity may be used to determine whether a value of the standard preparation obtained from a small sample is within the limits expected for random sampling error. In that case it would be justifiable to obtain a reduction of error by utilizing the values which have been established in the past, instead of the sample value obtained for that standard preparation. — EDMUND W. JOHN DE MAAR, M.D.

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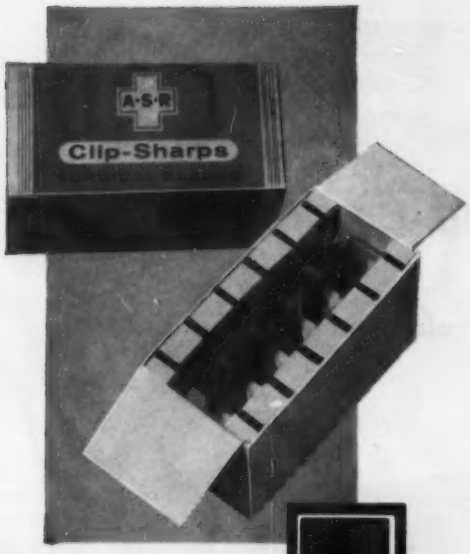
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References

References 1 to 9 contain many of the original articles on biometry and biological assay. References 10 and 11 contain short introductory articles into the subject of biometry, biological assay, and biological standards. References 12, 13 and 14 provide the latest information on new developments in the field.

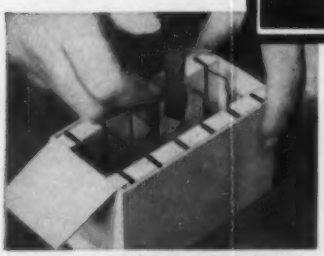
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A·S·R **Clip-Sharps**

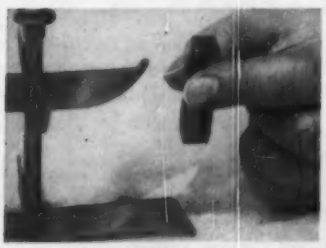
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

Clip-Sharps® are convenient wire clips containing 24 unwrapped A.S.R. Command Edge Surgical blades. There are six clips per box, protected by rust inhibiting paper.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

If you do not wish to sterilize the entire clip of 24 blades, remove only the required number from the clip and place them on the rack arm.

All A.S.R. Surgical Blades are Sharpometer tested. The A.S.R. Sharpometer, *only* device of its kind, measures the critical edge-fineness of every lot of A.S.R. Surgical Blades. These tests enable A.S.R. to guarantee . . . precise, uniform sharpness and dependability for every single blade!

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H-5

Food Should Look Good Enough to Eat

Appealing food displays step up counter sales

NADINE TUCKER

BECAUSE the enjoyment and satisfaction received from food play an important part in the individual's daily life, food service should be considered from the esthetic as well as the nutritive and physical standpoints. The final goal, *i.e.* a satisfied cafeteria clientele, is influenced by many factors. A great many considerations, procedures and practices must enter into the attempt to attain nutritionally adequate and esthetically enjoyable meals.

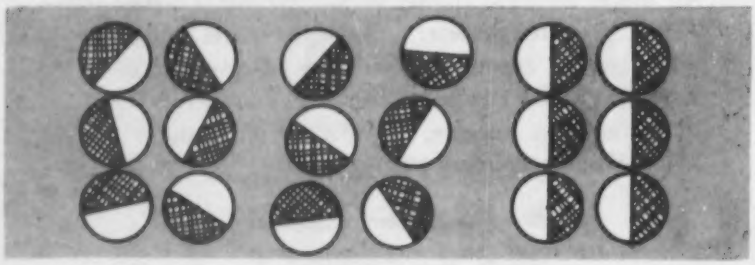
Well planned menus plus the use of good quality products in the production of the menu items are the basic foundation of good food service. There are also many procedures, classed as food merchandising, which may make the difference between excellent food service and that which is mediocre. Among these possible ways of improving food service through merchandising are: presenting an appealing food display (which includes cleanliness of serving counter and area as well as neatness and good arrangement of the display and the use of eye-catching food items through effective garnishing), presenting a variety from meal to meal and from day to day, and including an occasional surprise element in the menu offering.

In cafeterias many various principles of good food merchandising can be applied to achieve better food service and consequently a more satisfied clientele. Following is a summary of the practical application of some of these principles:

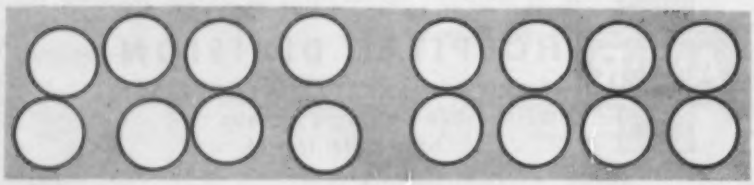
Place salads on the display counter in straight, even rows so that the basic line of the salad is uniform for each row, as shown in Graph 1.

Miss Tucker is a dietetic intern at Barnes Hospital, St. Louis.

Graph 1: Not this ..... or this ..... but THIS



Graph 2: Not this ..... but THIS



Place salads on counter with regard for eye appeal by contrasting color, shape and texture; but follow some consistency in order so the customer can know what to expect. This will allow a quicker selection and gives the customer a certain sense of "security" as it is something he can depend on.

Example: Place salads that are a daily menu item (as fresh green salad, molded salad, and cottage cheese) in the same position on the counter every day.

Place other foods on the counter according to a pattern.

Entrees: Whole cuts first
Meat extenders second
Meat substitutes third

Breads: White first, then rye, whole wheat and raisin

Desserts: Cookies, then fruit and pie
Pudding, then fruit, and cake

Place other foods so they will appear to best advantage:

Pie point is toward the customer.

Icing side of cake is toward customer if piece is wedge shape; if square, it sits erect.

All individually dished foods are placed in even rows on the counter, as shown in Graph 2.

Prevent messy edges on salad and fruit dishes. Always wipe rims with clean cloth before placing on counter.

Don't fill juice glasses so full that they spill when picked up by customer or are "pushed up" by employe. If juice glass tray has spilled juice on it, absorb this with a clean cloth or change trays.

If pieces from salads drop off plates to the ice, remove immediately. Always keep ice counter clean and free of foreign particles.

Keep counters of all units wiped free of spilled food while serving. Use



Sexton Quality Foods



Mountain View Hotel, Gatlinburg, Tennessee

Exquisite coffee

In many a famed hostelry, where guests expect the best as a matter of course, Sherman Blend exquisite coffee is served as a matter of sound economics. It embodies all we have learned in nearly three-fourths of a century in roasting and blending coffee to please the public taste. Yet so little more does it cost per cup, with a full forty cups to every pound, that it is a genuine economy to serve it and insure utmost guest pleasure.

JOHN SEXTON & CO., CHICAGO, 1955

SOME GARNISHES THAT MAKE FOODS APPEALING

SALADS

Parsley sprig at small tip end of blushing pear
Shredded cheese on pineapple ring or lettuce wedge
Stuffed date or prune with orange slices
Parsley sprig in center of circle of orange slices
French fruit salad with peanut butter dressing
Lettuce wedge with radish rose or green pepper ring or tomato
Spiced peach in fence of celery sticks
Fresh or canned fruit salad with watercress, parsley or mint leaf
Pickled beets on endive with chopped hard cooked egg
California Waldorf salad with sour cream dressing, chopped nuts
Orange slices or apricot halves with shredded coconut
Maraschino cherry, chopped nuts, or cream cheese rosette on fruit salads
Olive slice or pimiento strip on cream cheese-stuffed celery sticks or stuffed eggs (use pastry tube for stuffing process)

VEGETABLES

O'Brien dishes—red or green pepper or pimiento pieces with corn, potatoes, squash
Chopped chives on turnips or peas (either buttered or creamed)
Chopped parsley on potatoes, cauliflower, turnips, parsnips
Paprika on turnips, cabbage
Chopped bacon and onion on green beans, potatoes, cabbage
Maraschino cherry on grapefruit half (fresh or broiled)
Chopped parsley on golden squash soup

DESSERTS

Peach slices, maraschino cherry, chopped nuts, or coconut on cream or tapioca pudding or blanc mange
Meringue on bread pudding and cream pudding
Whipped cream on gingerbread
Cherry upside down cake with whipped cream and red cherry

New STEAM-CHEF Cafeteria Pan Steamer

Streamlines Cooking!



This new model, another first by STEAM-CHEF, saves handling, time and food. Many foods can be steamed in standard cafeteria pans and placed directly on serving tables without transfer. This reduces handling and cleaning of pots and pans, and avoids damaging foods such as asparagus and broccoli. Frequent small-lot cooking in cafeteria pans is fast and convenient, and insures freshly cooked foods during busy mealtime rushes. This helps eliminate left-overs and costly throw-out losses.

Built to accommodate twelve standard 12" x 20" or twenty-four half-size cafeteria pans, this STEAM-CHEF can also accommodate standard steamer baskets when desired. The versatility and many time-saving conveniences of the new Cafeteria Pan STEAM-CHEF make it ideal for thousands of kitchens.



● *For the complete story of economical, practical and efficient steaming, write to:*

THE CLEVELAND RANGE CO.

"The Steamer People"

3323-G LAKESIDE AVENUE · CLEVELAND 14, OHIO

break in customer line to clean all soiled surfaces (glass as well as board and metal) of serving area.

Never leave cleaning cloths above counter in sight of customer.

Check cleanliness of dishes as served. Never put food on a dish that is not absolutely clean. Place unclean dishes under counter inconspicuously.

Avoid spreading a serving of food all over the plate or dish.

Do not drip particles of food onto edges and rims of the serving dish or plate.

Keep serving unit of a food whole as much as possible. If the serving is broken before or during serving, arrange it on the plate or dish as a whole, complete piece.

Try to serve standard portions because uniform servings contribute to attractiveness of food display as well as being necessary for portion control.

Place the accompaniment to a food beside the food on the counter, but do not serve with the food unless the customer requests it.

The art of attractive presentation of food includes garnishing. The choice of a garnish (as well as the choice of a suitable accompaniment) must be made so as to give color, flavor and shape and texture contrasts. In this way the garnish will make the food both more appealing and more enjoyable. Remember to keep within the principles of good design, and to avoid elaborate, grotesque combinations; simplicity is a good rule to follow in garnishing.

A brief survey of types of garnishing is shown in the table above.

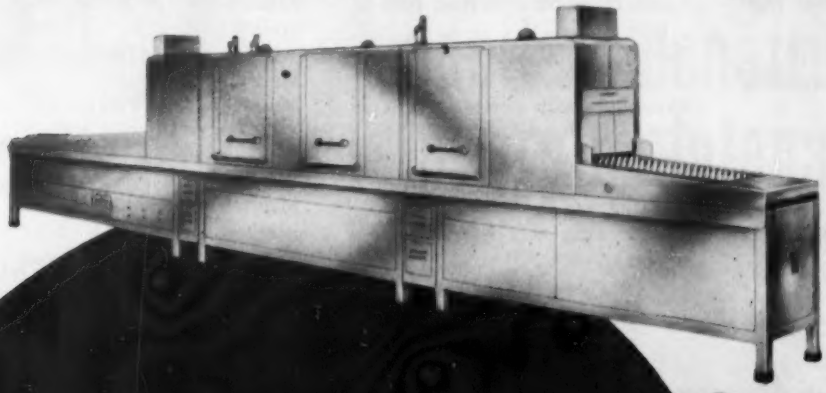
Well chosen accompaniments to menu items are of benefit in the project of pleasing the cafeteria clientele and making the food service attractive. At the top of page 120 is a list of some favorite combinations.

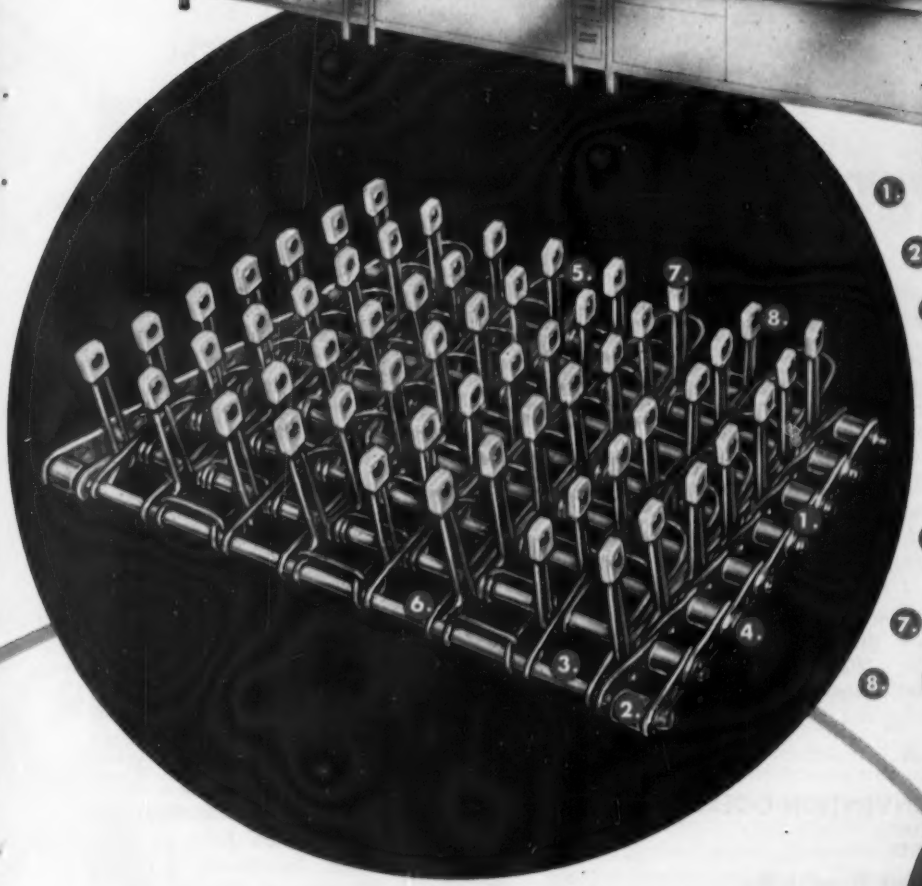
(*Continued on Page* 120)

MOST FOR YOUR DOLLAR

HOBART SERIES FT DISHWASHERS

with Exclusive All-Stainless Steel Conveyor





1. Side Bar—stainless steel
2. Roller—stainless steel
3. Conveyor Rod—stainless steel
4. Cotter Pin—stainless steel
5. Resilient Flight Wire—specially treated stainless steel for cushion-loading
6. Spacer—specially treated stainless steel
7. Guard—molded nylon tip
8. Rivet for Guard—stainless steel

FOR PROVEN DOLLAR-SAVINGS in costs where dishes are handled in volume, you can't beat the Hobart Flight-Type Dishwasher with exclusive all-stainless steel conveyor. Here's dish handling and need for human supervision cut to the absolute minimum.

It represents a fair-sized investment. Big enough to make it vital to you to get utmost value per dollar for the utmost in cleanest, longest-lived performance.

Take time to compare. Take the vital conveyor, for example. Hobart—and *only* Hobart—gives you a Flight-Type conveyor with *every part* but one made of stainless steel. (And that one is the easily-replaceable molded nylon tip added to protect inside hollow ware glaze.) And what gives long life and better sanitation standards than stainless steel? It's a costlier construction than all-nylon conveyors (which we can furnish)—but for sheer value, this exclusive feature alone should make you decide on Hobart stainless steel construction.

Feature by feature and model by model, Hobart dishwashers of all types offer you the most in value for your special operation. Send the coupon today for proof . . . . . .

The Hobart Manufacturing Company, Troy, Ohio.

Hobart Dishwashers proudly bear this seal of approval

Hobart machines

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

THE HOBART MANUFACTURING COMPANY, Troy, Ohio
Dept. ADV.

☐ Please send me without obligation your new illustrated, descriptive Dishwasher Booklet.

☐ Please call with full information.

NAME _____ TITLE _____

COMPANY _____

ADDRESS _____

CITY _____ ZONE _____ STATE _____

Hot (spiced) applesauce with roast pork
Cabbage and corned beef
Horseradish relish or horseradish sauce with corned beef
Sauerkraut and whipped potatoes with spareribs
Candied or whole baked yams with baked ham
Broiled peach half or pineapple slice with baked ham
Spiced crabapple with roast pork or beef
Bread dressing with roast pork or baked pork chop
Dumplings with stewed chicken
Fresh tomato relish with liver
Tartare sauce with shrimp or fish
Hollandaise sauce with broccoli, cauliflower or asparagus
Orange sauce with whole or sliced beets
Raisin sauce with baked ham
Broiled grapefruit half with roast meats
Mint jelly with lamb
Mushroom sauce with omelet, scrambled eggs, or meat loaf
Tomato sauce or chive sauce with meat, cheese or egg dishes
Maple sirup and bacon with hot cakes
Currant jelly with cheese puff

Dietitian as a Buyer Takes Spotlight at A.D.A. Meeting

MARY P. HUDDLESON

WELL over 3000 of the more than 11,000 members of the American Dietetic Association attended the 38th annual meeting in historic St. Louis, October 18-21.

The increasing importance of the dietitian as a buyer or as the one who has primary influence over the decisions of the institution's purchasing agent was indicated by an exhibit of 258 booths manned by the nation's leading manufacturers and distributors of foods and food service equipment. The vast interior of Kiel Auditorium and the city's two leading hotels teemed with dietitians, equipped with sharp minds, pencils and appetites, determined to sample the array of new ideas and new foods.

Most impressive were the small group clinics and conferences concerned with effective administration of food service. These daily gatherings dealt with specific problems of cost control, work simplification, selective menus, equipment, record keeping, mental hospital food service, dietary consultant services, quality food production, layout, supervisory training and—last but far from least—improved teaching of organization and management at the college and internship levels. The last mentioned group was led by Mary K. Bloetjes, now professor and head of institution management at Cornell University, who won distinction as a hospital dietitian and later a doctorate in management.

At the conference on record keeping, led by Margaret Gillam, it was stressed that records should be viewed as tools in controlling procedures and in accumulating facts, and as time-savers. The dietitian needs records, first, to operate efficiently and, second, to present concise and pertinent facts that will aid her administrator in making informed and intelligent decisions.

At the session, Edith Jones, chief of the nutrition department of the National Institutes of Health, Bethesda, Md., recommended the pie-shaped summation of food service expenditures. Hers showed labor expenses to be nearly three times that of raw food. The "big business" aspect of this session was further indicated by Margaret O'Connell of Harper Hospital (650 beds), Detroit, who viewed her main kitchen as the manufacturing area where foods are "sold" to the pay cafeteria and other areas, and whose standard recipes carry total cost and portion cost. Louise Hatch of Massachusetts General Hospital, Boston, reported 16 per cent of the total hospital expenditures going to the food department. Helen Cassidy, production dietitian of St. Luke's (550 beds), New York, who does all buying, stressed prompt payment of all

(*Continued on Page* 170)

TRENDS SPOTTED BY CONVENTION-GOERS TOWARD—

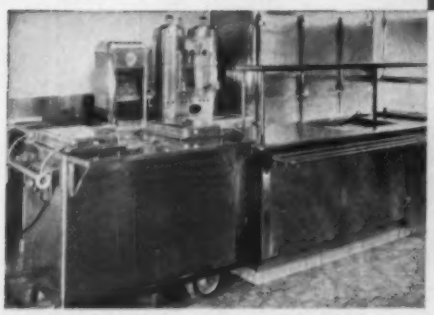
Prefabricated frozen meats.
Low calorie (low fat or fat free) milks.
"Spreads" instead of butter or margarine.
Frozen desserts instead of ice creams.
Use of prepeeled and cored apples.
Use of prepeeled onions and potatoes.
Preparation and use of foods that will stand up well until served.
Increased preference for plastic dishes now that driers are available with dishwashing machines.
More attention to rotation of foods in storage to avoid possibility of off-flavors.
More attention to "little ingredients," such as real vanilla at $12.50 a gallon rather than the imitation at $2.50.
Kitchen planning in the light of what may be maximum production years later.
Planning for future expansion at time of new construction, including location of dining areas.

ideas

from Blickman-Built award-winning food service installations

sanitary construction lowers maintenance costs

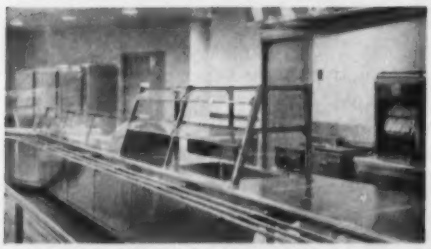
AT BAYLOR UNIVERSITY HOSPITAL, DALLAS, TEXAS



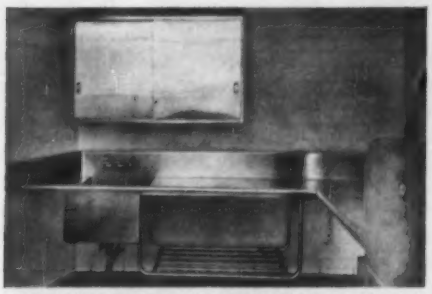
FLOOR PANTRY—showing Blickman-Built food conveyor. Note stainless steel serving counter with round-corner bottom. Pantries have complete service facilities.



GENERAL VIEW OF MAIN KITCHEN — showing food conveyors lined up opposite cook's tables. When loaded, conveyors are wheeled to elevators and taken to individual floor pantries. Stainless steel cook's table typifies sanitary construction of all equipment, featuring round corners, rolled edges, seamless crevice-free surfaces. Note built-in bain marie.



CAFETERIA—close up of stainless steel serving counter. Round-corner bottom, seamless top, welded tray slides, elimination of horizontal trim—all promote cleanliness.



FUNCTIONAL DESIGN AIDS SANITATION in main dish pantry. Stainless steel clean dish table with built-in round-corner sink. Wall-mounting eliminates leg obstructions, facilitates cleaning. Welded tubular undershelf is suspended from dish table, leaving floor clear.

• The stainless steel equipment in this prize-winning installation features construction details which reduce time and labor required for cleaning. For example, wall-mounting of sinks and dish tables leaves floor areas unobstructed for rapid, thorough cleaning. Stainless steel pipe enclosures prevent accumulation of dirt and grease on inaccessible surfaces. Welded tubular undershelves are readily cleaned on all surfaces. Round-corner sinks, rolled edges and seamless stainless steel surfaces facilitate cleaning by eliminating dirt-collecting crevices. Such details help maintain the highest standards of hospital sanitation. In addition, durable welded structures assure years of repair-free service life. Maintenance costs are low as a result.

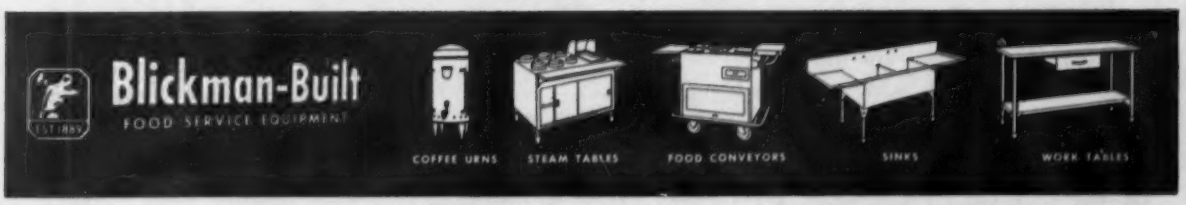
The installation serves approximately 55,000 meals every month to patients and employees. Service to patients is handled through a well-planned decentralized system. Pre-heated food conveyors are loaded with bulk food in the main kitchen and transported to individual floor pantries. There, trays are set up and distributed to patients.

Designed and equipped by S. Blickman, Inc., this installation won a Merit Award in a recent Institutions Food Service Contest. You, too, can realize substantial savings in labor and maintenance costs by specifying "Blickman-Built."



***Send for illustrated folder** describing Blickman-Built Food Service Equipment — available in single units or complete installations.*

S. Blickman, Inc., 1512 Gregory Ave., Weehawken, N. J.



You are welcome to our exhibit at the Association of Operating Room Nurses Convention, Hotel Statler, Boston, Mass., Booth Nos. 28 and 29, Jan. 30-Feb. 1

Paper Food Service Meets With Favor

Reporting after two years' experience, this hospital has found paper service silent, sanitary and economical

ARNOLD S. LANE

WHEN we first studied the use of all-paper food service, its cleanliness struck me as an inescapable fact, since every plate, cup or dish would be thrown away after a single use. It appeared, too, that paper service would offer definite advantages from the standpoint of economy. But there were other important factors to be considered. Chief among these was the fairly prevalent belief that paper cups and plates would not be acceptable to our patients as a regular medium of food and beverage service.

The conviction was sufficiently strong in my mind, however, to want to try out my theory. A full-scale test was accordingly arranged.

Based on our average of 350 meals per day served to patients and staff, a complete set of paper cups, dishes and new plastic-coated paper plates was decided upon and a two-month supply of all items was ordered. Our kitchen staff received advance instructions as to the proper size paper container or plate to use for each of the various types of food and beverage which we serve.

On July 23, 1953, the complete change-over to paper service was initiated. We informed our patients of the experiment we were launching by placing an explanatory note on each food tray. They were all notified that they could have china if they wanted it.

Nurses and administrative personnel asked questions and reported the opinions expressed. I personally interviewed every patient we served during the two-month trial period. To double-check the results and make sure that answers weren't slanted in face-to-face interviews, we circulated a questionnaire to be answered anonymously. Here, briefly, are the results:

Approximately 650 patients used the paper service during the test period, including people in every economic bracket, from the low income group to the very wealthy. Not a single patient refused to accept the idea of having meals served with paper service.

Ninety-eight per cent found nothing wrong with the taste of the food. Eighty-five per cent had no trouble at all eating or drinking from any of the paper plates, cups or containers. Food and liquids were found to stay just as hot served on paper as on china. Of the 650 patients who used paper service during the test period, only four requested china. In all, the results of the test far exceeded my expectations.

One of the important things we learned from the test was that paper service is economical. Following the two-month trial period, we kept complete cost figures for the six months from Oct. 1, 1953, to March 31, 1954. Based on this six-month period, we would show the following savings on an annual basis:

Dishwashing labor (2 full-time jobs and 1 half-time job eliminated in the kitchen)	$4,500.00
Elimination of glass and china breakage	447.52
Reduction in water bill	19.42
Reduction in electric bill (for heating water)	215.00
Cleaning of septic tanks	450.00
Reduction in use of detergents	60.00
Total	$5,691.94

Against these savings, we must of course put the cost of the paper cups, plates and dishes. When we installed paper service, we estimated it would cost $4600 per year. Our actual experience to date, however, shows an average of only $315.66 per month, or $3,787.92 per year, which will mean a saving of approximately $2000 in food service. The average cost per patient for serving a meal with all-paper service is less than 3 cents.

Disposal of the paper cups and dishes has not added to our costs since it is taken care of in the daily trash and garbage collection, for which we are still paying the same monthly service charge. Moreover, time is saved in scraping the paper plates, since less care has to be taken in handling them and tossing them into the waste cans than was formerly consumed in scraping and rinsing the china plates, placing them in the dishwasher, and subsequently replacing them on the shelves. This last operation, incidentally, used to be a constant source of complaint from the kitchen personnel, who objected to having to lift heavy racks of dishes from the dishwasher. In the 12 months preceding installation of all-paper service, 12 of our kitchen employes resigned for this reason. Since we converted to all-paper service, we have had no resignations.

Another important advantage which the new service offers is the fact that it is noiseless. Our patients were particularly impressed with the cessation of the clatter, heretofore inevitable, of china and glassware being stacked. Needless to say, there are few places where such noise abatement is more welcome, or more helpful, than in a hospital.

Some hospital administrators may envision problems because of the large number of paper cups, plates and dishes which have to be stored in order to keep an adequate supply on hand. Our experience may be illuminating. We carry a two-month supply

Mr. Lane is administrator, Point Pleasant Hospital, Point Pleasant, N.J.

HOW HEINZ KETCHUP GETS ITS CAN'T-BE-COPIED FLAVOR



1 To get tomatoes good enough for Heinz Ketchup, we had to develop our own private strain on our Heinz experimental farms. Here they're checked to make sure they were at the peak of ripeness when picked.



2 The spices are weighed and blended, following Heinz secret, time-tested formula. The vinegar and sugar are carefully and accurately measured in. The onions, mild Californians only, are added.



3 We take our time cooking it down—for you can't rush good ketchup. And the results in batch after batch—thick, deep red and savory—are assured by Heinz know-how. The skills of our 50 years of ketchup making can't be matched overnight.



4 Make sure the can't-be-copied flavor of Heinz Ketchup is working for you. Served as a condiment or cooked into the dish, Heinz does more for food than any other ketchup. For the difference it makes, the cost is trifling. Order the famous 14-ounce bottle or #10 tin.

HEINZ 57 KETCHUP

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

of paper cups, plates and dishes in the same storeroom which our glassware and china formerly occupied. The storage space is 14 by 12 feet, with a 9 foot ceiling. The cardboard boxes in which the cartons of paper cups and dishes are shipped are not heavy and can be stacked on top of each other to near ceiling height. These large boxes contain 25 to 30 small cartons, each sealed, with 50 to 100 items in each carton. Only one or two of these smaller cartons of each item are taken to the dietary department at a time, the same closet space previously occupied by china and glassware being used. These cartons are opened as needed by the one person who sets up the trays, so they are not handled by more than one person. The person serving the food simply fills the plates or containers as they pass her—she doesn't have to touch them. (We use a centralized service in our dietary department.)

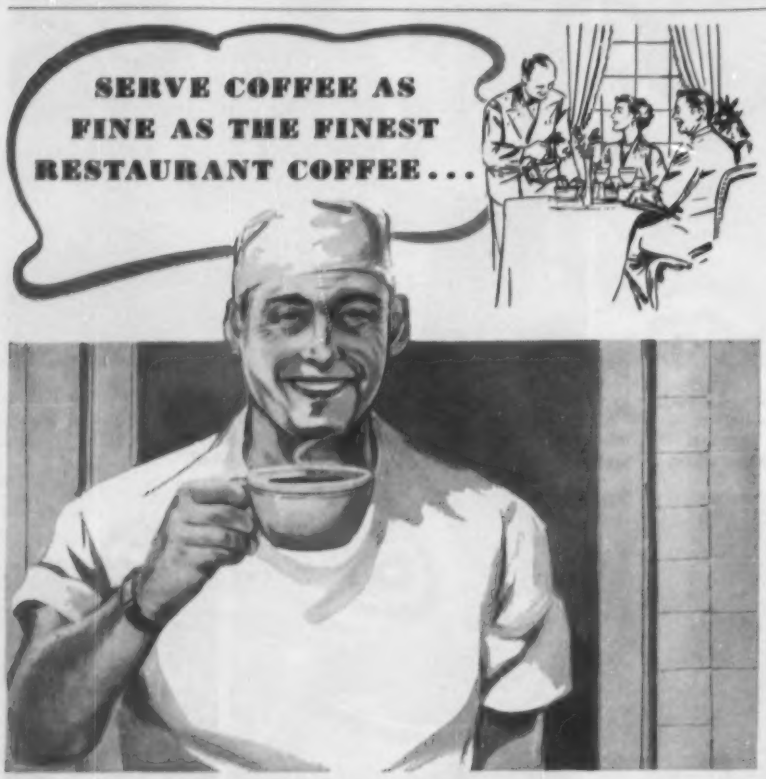
The board of trustees, medical staff and women's auxiliary of Point Pleasant Hospital carefully observed the results of the trial period and all approved a permanent change-over to paper service. Indicative of the reactions of our patients are these statements made at the hospital during the test period:

A male patient, formerly assistant public health officer of a near-by city: "I think the new paper service is a wonderful thing. It is sanitary. It eliminates noise—an unpardonable sin in a hospital. There is no breakage as in china and glassware, and the paper plates and cups are tasteless since they are made of coated paper. As a health officer inspecting eating establishments, I always stressed the need for washing all dishes and glasses for at least one minute in water at 180°F. Yet, in the many places where dishwashing was done by hand, we found that it was impossible for the human hand to stand water at this temperature for that period of time. Thus, many establishments were simply not abiding by minimum sanitation standards. Single-service cups and dishes do away with this problem."

Another patient, a waitress, said: "I like paper service very much. Because of the type of work I do, I notice particularly that the paper cups and plates are much lighter and easier to carry. They do not present any problem in actual use, such as cutting meat, and they are certainly cleaner than any other type of cup and dish."

Another woman patient said: "When I first saw the paper cups and plates, I didn't like the idea very much. Now I have grown accustomed to it. I still feel that for some hot liquids, I would prefer china. As far as paper plates are concerned, I was satisfied."

Nancy Kilpatrick, the hospital dietitian, reported: "We had almost no complaints about the new paper service. A few people requested china cups. They expressed no dissatisfaction with the paper plates and dishes, but instead welcomed the greater sanitation provided by them. My personal reaction was originally quite unfavorable, but I must say that within three weeks' time, I completely changed my opinion. Increased sanitation is, of course, the most important factor. There is just no substitute for a completely new, unused cup or dish for every serving. The much greater ease of handling paper service is another advantage—no dishes to wash, and lighter trays to carry. It used to take from 12 noon to 3:30 p.m. to clean up after our midday meal; now our kitchen force is all through by 1:45."



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There are many tastes to please in a hospital . . . nurses, patients, doctors, the administrative staff. In coffee *all* want *flavor*. Millions enjoy Continental Coffee because it has the *most* in flavor—delicious, winey-rich, full-bodied and unvaryingly fine.

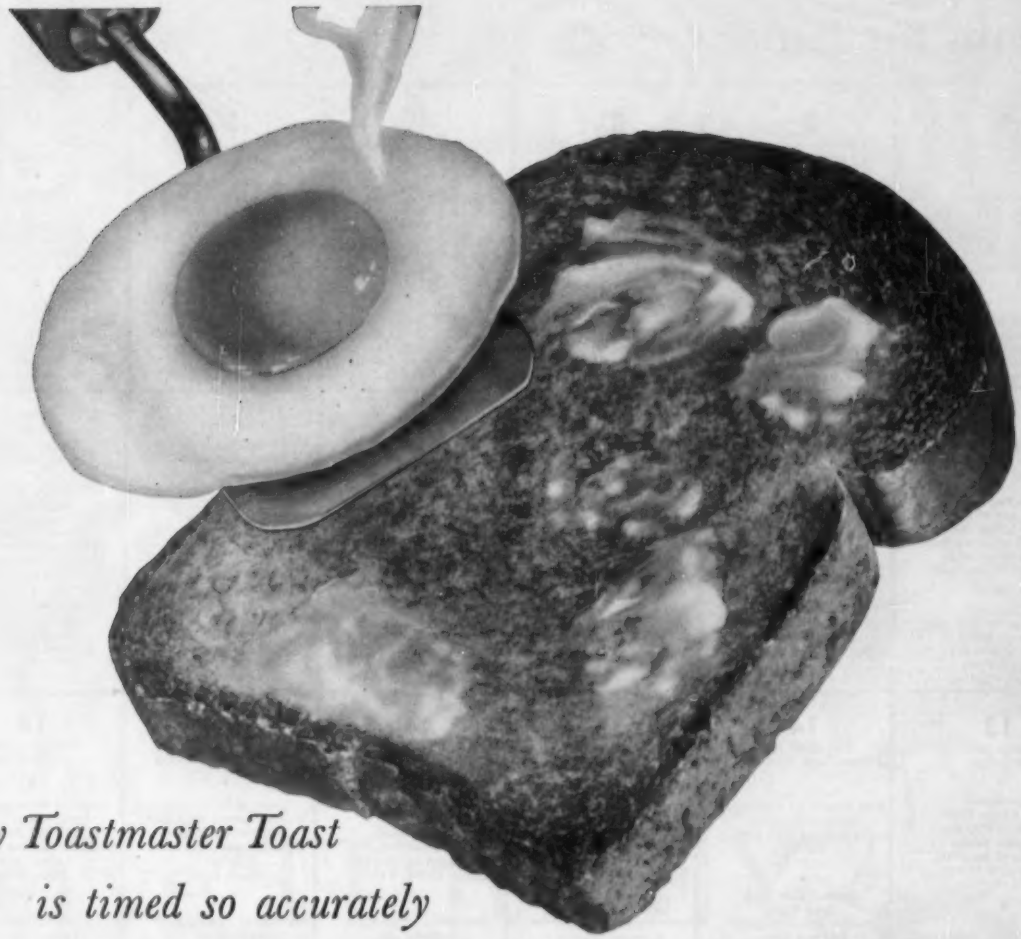
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Automatic Toasters



Hot-Food Servers

Menus for January 1956

1 Sliced Peaches Toasted English Muffin • Alphabet Soup Roast Prime Ribs of Beef Baked Potato Julienne Carrots Tomato Salad With Russian Dressing Vanilla Ice Cream • Corn Bisque Cold Sliced Chicken Buttered Spinach Riced Potatoes Lemon Gelatin	**2** Apricot Nectar Grilled Ham • Tomato Bisque Spanish Pork Chop Mashed Potatoes Buttered Green Lima Beans Lettuce Wedge With Thousand Island Dressing Prune Whip • Old Fashioned Potato Soup Frizzled Dried Beef on Toasted Bun Buttered Noodles Mixed Green Salad Fruit Cocktail	**3** Orange, Grapefruit Juice Scrambled Eggs, Toast • Beef Noodle Soup Roast Leg of Veal Parslied Boiled Potato Harvard Beets Pear Salad Lime Gelatin • Cream of Lima Bean Soup Grilled Chicken Livers Whipped Potatoes Buttered Peas Sliced Orange Cress Salad Strawberry Ice	**4** Chilled Applesauce Crisp Bacon, Toast • Tomato Bouillon Baked Ham Riced Potatoes Buttered Brussels Sprouts Marinated Cooked Vegetable Salad Raspberry Whip • Cream of Turkey Soup Baked Stuffed Peppers Julienne Beans Sliced Tomato Salad Sliced Peaches	**5** Pineapple Juice Scrambled Eggs • Vegetable Soup Smothered Steak Whipped Potatoes Buttered Carrots Tossed Green Salad With Blue Cheese Dressing Fruit Ice • Cream of Celery Soup Broiled Veal Pattie Fluffy Rice Tomato Pickle and Radish Salad With Savory Dressing Canned Peeled Apricots	**6** Grapefruit Juice Sweet Roll • Consommé Broiled White Fish With Parsley Butter Escalloped Potatoes Buttered Asparagus Lemon Chiffon Pie • Corn Chowder Salmon Salad With Sweet Relish Tomato Wedge Riced Potatoes Hot Rolls Orange Sherbet
7 Apricot Nectar Toasted English Muffins • Split Pea Soup Roast Leg of Veal Parslied Boiled Potato Buttered Green Lima Beans Frozen Fruit Salad Maplenut Chiffon Cake • Consommé Cheese Soufflé With Ripe Tomato Relish Tossed Greens With Fresh Fruit Tapioca Pudding	**8** Orange Juice Link Sausage • Bouillon Hot Sliced Turkey Steamed Potatoes Buttered Green Peas Gingerale Fruit Gelatin Salad Peach Ice Cream • Tomato Soup Scrambled Eggs With Ham Cubes Buttered Mixed Vegetables Hot Biscuits Sliced Banana in Cream	**9** Chilled Applesauce Crisp Bacon • Alphabet Soup Individual Beef and Vegetable Pie With Parsley Biscuit Crust Corn on the Cob Sliced Beet Salad Bread Pudding • Bouillon Creamed Eggs on Toast Green Peas Celery and Ripe Olives Cranberry Crisp	**10** Grapefruit Juice Scrambled Eggs • Cream of Corn Soup Braised Short Ribs Riced Potatoes Buttered Asparagus Pineapple and Grape Salad Vanilla Ice Cream • Cream of Celery Soup Broiled Beef Pattie Baked Potato Sliced Beet and Hard Cooked Egg Salad Black Raspberry Ice Cream	**11** Chilled Tomato Juice Crisp Bacon, Toast • Beef Bouillon Country Fried Steak Steamed Rice Buttered Spinach Tomato Half Stuffed With Celery and Olive Strawberry Gelatin Cube • Vegetable Soup Hot Sliced Beef Julienne Green Beans Romaine and Sliced Tomato Salad Whipped Cream Cake	**12** Pineapple Juice Link Sausage • Chicken and Rice Soup Sautéed Liver Potatoes au Gratin Stewed Tomatoes Lettuce and Pear Salad With French Dressing Blueberry Pie • Asparagus Soup Roast Chicken Steamed Rice Buttered Green Peas Waldorf Salad Lemon Gelatin
13 Orange Juice Jelly Roll • Consommé Broiled Lake Trout Delmonico Potatoes Spinach Soufflé Apricot and Grapefruit Salad With French Dressing Cherry Pie • Casserole of Creamed Tuna Duchess Potatoes Shredded Carrot Salad Apple Betty	**14** Grapefruit Half French Toast With Sirup • Noodle Soup Beef Stew With Vegetable Buttered Potatoes Peach Salad With Date Filling Lemon Ice • Cream of Corn Soup Cold Cuts Parsley Cubed Potatoes Buttered Beets Pineapple and Shredded Cabbage Salad Sunshine Cake	**15** Orange Sections Scrambled Eggs • Consommé Roast Chicken Buttered Peas Pineapple, Cheese Salad Chocolate Ice Cream • Cream of Mushroom Soup With Croutons Smoked Tongue Buttered Spinach Sliced Pears in Lime Gelatin Quick Coffee Cake	**16** Grape Juice French Toast With Jelly • Beef Noodle Soup Broiled Liver Rice and Gravy Julienne Green Beans Carrot and Raisin Salad Lemon Chiffon Pudding • Cheese Rabbit on Toast Grilled Bacon Buttered Broccoli Jellied Fruit Salad Vanilla Ice Cream	**17** Stewed Prunes Toasted English Muffins • Cream of Celery Soup Chicken Gumbo With Rice Buttered Cauliflower Pineapple and Kadota Fig Salad Apple Crisp • Cream of Tomato Soup Baked Macaroni Loaf Buttered Asparagus Celery Sticks Fresh Fruit Compote	**18** Pineapple Juice Grilled Bacon • Cream of Vegetable Soup Roast Leg of Lamb Escalloped Potatoes Buttered Lima Beans Tomato Aspic Prune Whip • Vegetable Soup Fricasse of Veal Baked Squash Waldorf Salad Cheese Cake
19 Apple Juice Scrambled Eggs • Alphabet Soup Pot Roast of Beef Oven Browned Potatoes Buttered Peas Stuffed Apricot Salad Black Walnut Ice Cream • Chicken Noodle Soup Savory Steak Buttered Rice Lettuce Salad With French Dressing Strawberry Gelatin	**20** Sliced Peaches Scrambled Eggs • Beef Noodle Soup Baked Halibut With Tomato Sauce Buttered Green Beans Celery and Olive Salad in Gelatin Butterscotch Blanc Mange • Cream of Asparagus Soup Green Stuffed Pepper With Rice Combination Vegetable Salad Chilled Pears	**21** Grapefruit Sections Crisp Bacon, Toast • Old Fashioned Potato Soup Veal Chops With Currant Jelly Whipped Potatoes French Fried Egg Plant Waldorf Salad Tapioca Cream • Oyster Stew With Oyster Crackers Peach Half With Grated Cheese Apple Pie	**22** Orange Juice Cinnamon Toast • Bouillon Broiled Chicken Stuffed Baked Potato Buttered Broccoli Celery and Olives Lemon Velvet Ice Cream • Cream of Asparagus Soup Baked Veal Chop Escalloped Potatoes Buttered Spinach Fruit Salad Vanilla Pudding	**23** Blended Citrus Juice Crisp Bacon, Toast • Cream of Pea Soup Broiled Cube Steak Whipped Potatoes Buttered Wax Beans Sliced Tomato Salad Fruit Cup • Chicken Soup Stuffed Hamburger Loaf Riced Potatoes Buttered Beets Tossed Greens With Roquefort Cheese Dressing Gingerbread	**24** Grape Juice Scrambled Eggs • Vegetable Soup Roast Veal With Dressing Stewed Tomatoes Grapefruit Salad White Cake With Chocolate Icing • Bouillon Lamb Pattie Escalloped Potatoes Head Lettuce Salad Cherry Gelatin
25 Pineapple Juice Grilled Ham • Consommé Broiled Liver Riced Potatoes Buttered Green Peas Cottage Cheese on Lettuce Soft Custard • Split Pea Soup Hot Sliced Chicken Whipped Potatoes Buttered Sliced Beets Fruit Salad With Whipped Cream Dressing Chocolate Cupcake	**26** Apricot Nectar Scrambled Eggs • Meat Loaf With Tomato Sauce O'Brien Potatoes Frozen Kale Head Lettuce Salad With Chutney Dressing Lime Snow • Cream of Chicken Soup Minced Beef Buttered Potatoes Green Beans Carrot Curls Chilled Applesauce	**27** Sliced Banana Hot Biscuits and Honey • Tomato Soup Broiled Halibut Steamed Rice Buttered Green Beans Sliced Beet and Hard Cooked Egg Salad Butter Pecan Ice Cream • Cheese Soufflé Parslied Potato Buttered Peas Tossed Greens With Fresh Fruit Lady Baltimore Cake	**28** Sliced Peaches Canadian Bacon • Cream of Corn Soup Baked Ham With Pineapple Sauce Potatoes au Gratin Buttered Lima Beans Apricot and Grape Salad Boston Cream Pie • Tomato Soup Broiled Beef Pattie Potato Balls Buttered Spinach Waldorf Salad Vanilla Ice Cream	**29** Grapefruit Sections Crisp Bacon • Beef Bouillon Baked Haddock With Lemon Wedge Whipped Potatoes Chef's Salad Lemon Snow Pudding • Cream of Mushroom Soup Baked Cheese Loaf Buttered Potatoes Buttered Asparagus Shredded Lettuce Salad Strawberry Shortcake	**30** Grape Juice French Toast and Jelly • Consommé Southern Fried Chicken Fluffy Rice Mixed Vegetables Pear Salad Orange Gelatin • Vegetable Soup Meat Balls With Gravy Mashed Potatoes Buttered Broccoli Sliced Tomatoes and Pickles Devil's Food Cake
31 Applesauce, Bacon, Muffins • Swiss Steak, Mashed Potatoes, Gravy, Buttered Carrots and Peas, Apple and Raisin Salad, Vanilla Blanc Mange • Cheese, Bacon and Tomato Rabbit on Toast, Asparagus and Egg Salad, Blueberry Pie					

Ready-to-eat or cooked cereals served on all breakfast menus.



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Serve TURKEY



Here are a few of many advantages turkey gives in hospital cookery:

- **IT'S ECONOMICAL.** With a plentiful year-around supply of high-quality turkeys, you can now offer this delicious meat on the everyday menu.

- **TURKEY IS A HIGH PROTEIN MEAT,** ideal for hospital serving.

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By.....

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Fire Safety Calls for Cooperation

Two useful devices that help to reduce fire hazards in Grand Rapids hospitals are the inspection check list and harmonious relations between hospitals and fire officials

ADRIAN RIGNEY

IN NO type of institution are the residents so dependent on the administration as are those confined in a hospital. The very nature of their illness may render them helpless in many ways. This very helplessness imposes a grave responsibility on the personnel of the hospital in case of an emergency, and those in charge are growing more and more aware of their obligation in this matter.

A high percentage of all prevention activities in the hospital is either directly or indirectly related to the prevention of fires and to the evacuation of patients in case of fire. To this end the fire inspector should have two direct lines of endeavor: first, to ensure the safety of patients by a fire evacuation plan if a fire occurs; and, second, to install and maintain fire prevention procedures and technics so that the probability of a fire has been reduced to a great degree. Good fire prevention technic can minimize the possibility of having to use an evacuation plan but it will never replace it.

In Grand Rapids we have developed a useful inspection form and check list for hospitals covering every area of the premises. This list and one of the forms used by the Grand Rapids Fire Department in notifying citizens of violations of the fire code are reproduced on pages 130 and 132. I believe that if the list is used to the full extent a complete survey can and will be accomplished. There is one thing it does not contain. It cannot tell you of the importance of good public relations and using common sense.

Great care and common sense must be exercised in making a survey of the smoking habits of the hospital's personnel as statistics show that three out of 10 fires are caused by the carelessly used match or cigaret. Good smoking habits should be developed by the staff, with no smoking allowed in out-of-the-way places. The hospital should provide places for smoking and make sure that smoking is done only in those places.

Good public relations with the executive housekeeper and the administrative departments is a prime requisite, for these people are just as interested as the inspector is in seeing

(*Text Continued on Page* 132)

The author is fire marshal of Grand Rapids, Mich.

Administrator's Views on Inspection Program

LEE W. YOTHERS

ONE of the most interesting and informative official visits in our hospital takes the form of the annual fire inspection. We at Ferguson-Droste-Ferguson Hospital look forward with interest and enthusiasm to the latest and the best way to improve, through education and information, the fire resistance of our facility.

We feel that the fire marshal who makes this inspection brings with him an armamentarium of useful information and technics which assist us in our daily job of providing maximum protection for our patients.

We look to Marshal Rigney as our expert in this field. His relationship is not that of a fire inspector but that of a consultant who advises us as to the best possible methods and equipment for the prevention and control of fire. It has become a matter of pride and competition between the marshal and our hospital staff and myself to produce more improvements in our facility than the minimal standards required by the fire ordinances in our town.

It is indeed comforting to make the inspection tours and check off the hazards as being adequately protected throughout our installation.

We are also interested in the comparative reports from our hospital with those of other hospitals in our community.

Our board of trustees has set the policy for our relationship with the fire marshal and it is, I am happy to say, one of 100 per cent cooperation.

We are interested in improvements at all levels of patient care and especially in the realm of fire prevention and safety.

Mr. Yothers is administrator, Ferguson-Droste-Ferguson Hospital, Grand Rapids, Mich.



A wide range of coordinated seating pieces from settee-davenports to side chairs.





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INSPECTION FORM FOR PUBLIC ASSEMBLAGE (HOSPITAL)
FIRE INSPECTION BUREAU, GRAND RAPIDS, MICH.

Owner or Agent
Location
Type of Occupancy
Construction

Fire Inspector **Date**
Fire Brigade
Fire Signal
No. Floors **No. Beds**

1. GENERAL CONDITIONS

a. Is the attic used for storage?
b. Were all locker rooms clean?
c. Were ash trays provided?
d. Containers for oily rags?
e. Were 3 foot aisles maintained?
f. Was the basement clean?
g. Do all doors open outward?
h. Is there storage under stairs?
i. Are all stairwells enclosed?
j. Do stairwells have handrails?
k. Do all floors have two or more means of egress?
l. Were outside premises clean?
m. Smoke barriers or fire walls no more than 125 feet apart?
n. Do all fire doors work properly?
o. No hooks and eyes, bolts or latches on exit doors?
p. Exit and hallway lights provided?
q. Are tunnels equipped with fire doors?

2. BOILER ROOM

a. Is boiler room enclosed, separate?
b. Does boiler have approved controls?
c. Condition of smoke pipe?
d. Distance from smoke pipe to wood?
e. Are oil tanks installed properly?
f. Are combustible materials stored in boiler room?
g. How are ashes stored?

3. FIRST-AID EXTINGUISHERS

a. Are extinguishers up to date?
b. Is there an extinguisher for every 2500 sq. ft. or no more than 100 ft. to nearest extinguisher?
c. Are all special hazards protected?
d. Does building have special equipment?
e. Condition of standpipe hose.

4. FIRE ESCAPES

a. Are fire escape routes plainly marked?
b. Are fire escapes blocked?
c. Egress doors equipped with panic bar?
d. Do all doors open easily?
e. Do cars or shrubs block escape?
f. General condition of escapes.

5. ELEVATORS AND DUMB-WAITERS

a. Are shaftways plainly marked?
b. Do elevators have safety gates?
c. Are shaftways made of fire resistive materials?
d. Does penthouse have extinguisher?
e. Does escape work on elevator?

6. SPRINKLER SYSTEMS

a. Is stock closer than 12 inches to heads?
b. Where is reserve supply of heads?
c. Are all systems properly marked?
d. Are sprinkler plugs available?
e. Do shut-offs have wrenches?
f. If wooden structure, REC sprinklers?
g. If fire resistive, shall we recommend additional sprinklers?
h. Linen and dust chute sprinkled?

7. KITCHEN

a. Is the range properly installed?
b. Is the range equipped with filters, hood and vaporproof lights?
c. Does the kitchen have approved extinguisher?
d. Is vent properly installed?
e. Is fan switch easily accessible?
f. Extinguishing system in duct?

8. LAUNDRY

a. Is laundry isolated?
b. Are steam lines protected?
c. Are lint traps cleaned frequently?
d. No flammable spot remover used?

9. EVACUATION

a. Does hospital have evacuation plan?
b. Last test of alarm bell?
c. Are alarm systems wired properly?
d. Exit lights and panic bars provided?
e. Is personnel adequately trained?
f. Are beds allowed in hallways?
g. Are doorways adequate for evacuation?
h. Adequate blankets, wheel chairs or cots in case of emergency?
i. In total evacuation, where will patients be taken?
j. Are stairwell doors self-closing?
k. Are flimsy decorations allowed in hospital?

10. HAZARDOUS LOCATIONS

a. How is oxygen supplied to patients?
b. Cyc. & ethylene stored in well vented room, with proper wiring and ventilation?
c. Type of gases and storage facilities?
d. Is operating room properly wired?
e. Is Meggar board or equivalent in use?
f. Does hospital have auxiliary lighting system?
g. Is air recirculated in operating room?
h. Are flammable liquids properly stored?
i. Are all transoms removed?
j. Is carpenter shop approved?
k. Is laboratory approved?



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CITY OF GRAND RAPIDS FIRE DEPARTMENT
Hazards Report

Inspector _____
Station No. _____
Telephone _____

Address _____ Date _____
Name _____ Type of Occupancy _____

The following hazards were found to exist on premises of the above address at the time of inspection. The Grand Rapids Fire Department is asking your cooperation in maintaining a safe city by correcting the hazards noted.

Heat Appliance		Oil Storage		Flammable Liquid	
Smoke Pipe		Stairways		Storage in Garage	
Furnace Clearance		Burning		Temporary Wiring	
Rubbish		General		Over Fused	
Storage of Ashes		Exits		Miscellaneous	

Remarks _____

Inspector _____

Approved ☐ Date _____
Inspector _____

This notice is sent to a building owner when violation is first observed.

FIRE INSPECTION

(*Continued From Page* 128)

that all is well. The particular horror of fire in a hospital will receive more and more attention from these officials.

Making the hospital a safe place to be is a worthy goal. Making the hospital a safe place to work is excellent public relations, and Grand Rapids hospitals are doing their best to accomplish both goals.

Housekeeper Agrees: Inspection Program Works

EMILY C. DEMING

FIRE inspection is an ordeal to be dreaded in so many hospitals that it is a pleasure to have been asked to comment on its meaning and value to us here at Butterworth Hospital, and especially as it affects housekeeping.

We look forward to Marshal Rigney's visits as a pleasant, helpful experience. He is strict, thank heaven, terribly strict, so one feels very secure when requirements have been met, knowing that the ultimate in pre-emergency measures has been taken.

During the long pull of our extensive building program he was ready to come at any time to advise and counsel with us on the frequent problems—whether it was safe storage of a shipment of mattresses which arrived before that area could be readied; a temporary evacuation plan for a restricted area under construction; a safe method of making a "fire escape" door just that; how best to make fire lanes in overcrowded storage areas, and so on.

There has never been a problem that I've not felt free to discuss with him or members of his staff, and never been a time when the answers have not been complete, incisive and firm!

He is delighted to meet a request to do a "fire" demonstration for new employes, and the added emphasis of having a fireman actually teach them is of inestimable value to our employes, and to the hospital safety picture. He has given us exact formulas for treating Christmas greens so that the house can be gay and the housekeeper can sleep nights. A request to verify the reported "flash point" of a new product receives prompt attention and a complete report is sent or phoned to us.

So there is no terror in either the planned or the unexpected fire inspection here at Butterworth Hospital. We are always glad the marshal is coming; glad that he recognizes that the basic service of housekeeping has real meaning in a fire prevention program. He contributes to our department directly as teacher and guide. The everlasting vigilance of his department contributes much to the peace of mind of everyone charged with patient safety.

Miss Deming is executive housekeeper, Butterworth Hospital, Grand Rapids, Mich.

NEW! 3-dimensional

LIGHTING for HOSPITAL CORRIDORS

RECESSED UNIT



◀ HOLOPHANE F-1823
Series of In-Bilt Units

HOLOPHANE No. C-824 ▶
Surface Attached Unit



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Halls and corridors, with constantly heavy traffic of patients, staff-members and visitors, are actually among the most important areas in the hospital. With the introduction of several new lighting units Holophane has brought a new concept to the illumination of hospital corridors . . . Equipped with specially-designed prismatic CONTROLENS®, the new Holophane luminaires provide "three-dimensional" control of light . . . directing it not only to the floor but also to the ceiling and the walls. Reflections from these surfaces produce perfectly-balanced, glare-free illumination, resulting in an atmosphere of dignity, safety and visual comfort . . . Inquiries are invited for data on F-1823 (recessed) and C-824 (surface attached).

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Good Housekeeping Is Good News

In order to attract recruits to their field, executive housekeepers must make a serious effort to make their profession known to the public

JANE BARTON

IT IS a paradox and perhaps a sad commentary on modern society that, to the average newspaper editor, bad news is better news than good news. The American public is regrettably bloodthirsty in its reading habits, and wallows happily in tales of death and disaster while it skims lightly over reports of the uplifting activities of the boy scouts, the girl scouts, the W.C.T.U., and, even the National Executive Housekeepers Association.

The hotel housekeeper who manages to burn down the premises by permitting dust to accumulate in an unventilated air shaft and the hospital housekeeper who indirectly helps to blow up a patient on the operating table because she doesn't know how to maintain conductive flooring can count on an avid and eager audience for the account of her activities. Whereas the good housekeeper who just plugs along from day to day, giving good service to her public, unobtrusively and without fanfare, generally remains unknown to the newspaper reading public.

These facts seem to make the thesis that "Good Housekeeping Is Good News" seem farfetched if not downright silly. But I am persuaded that there *is* an audience for news of good housekeeping practices—if that news is presented in the right way to the right public at the right time.

From a paper presented at the Central District meeting of the National Executive Housekeepers Association, Cincinnati, March 1955.

The mediums for the dissemination of news about housekeeping are many and various. There are newspapers; general magazines, particularly those that cater to the interests of women; professional journals in the hotel and hospital fields; the employe publications of your own institutions, and, of course, radio and television. Finally, there is the spoken word: that is, talks to clubs and civic groups, and, most important of all, word-of-mouth advertising—what your patients, guests and fellow workers say about you. But we'll get to that later.

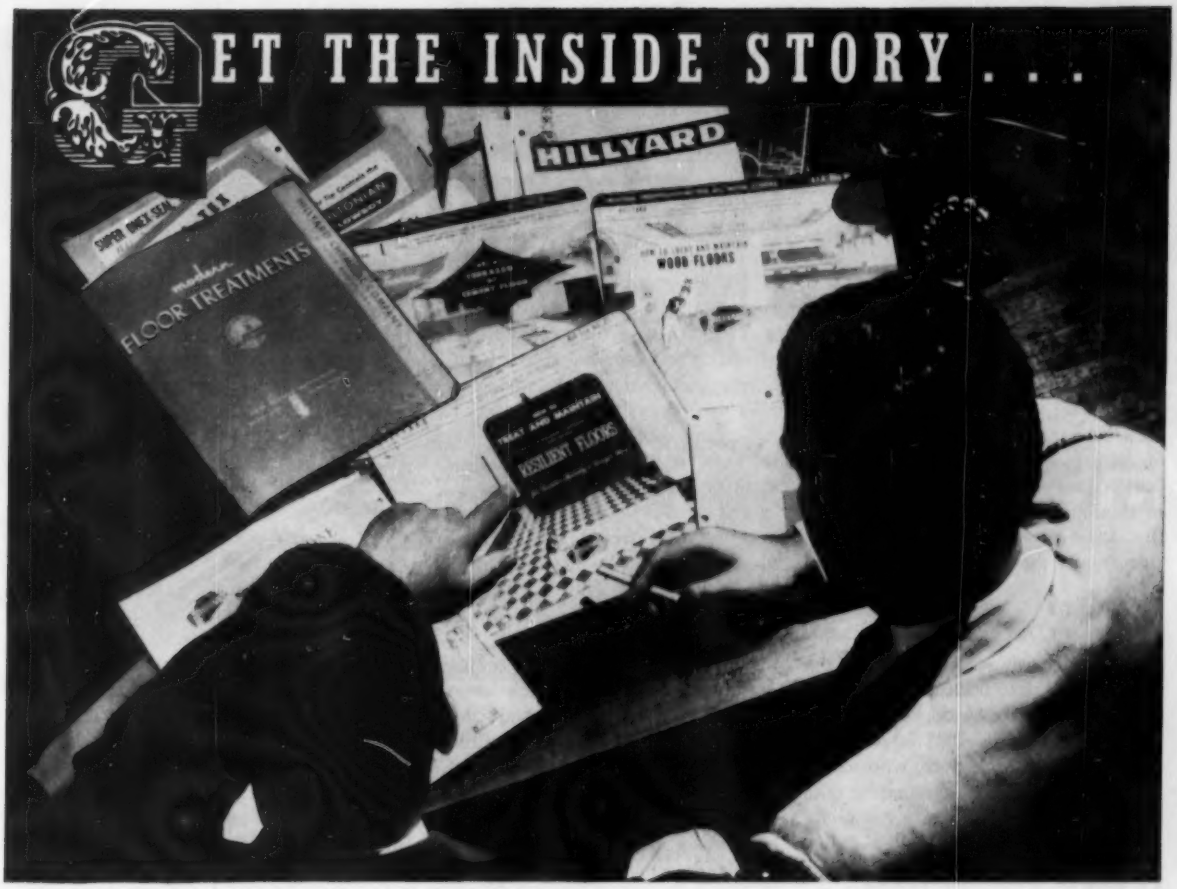
WHAT MAKES A STORY

Let us discuss four aspects of housekeeping and the news. First, what makes a good news story? Specifically, what phases of institutional housekeeping are likely to appeal to editors and their readers? Second, what information needs to be assembled? Third, how should reporters and editors be approached so that their interest and cooperation will be assured? Fourth, in what form should the material be cast?

First, let's try to determine what constitutes a legitimate news story—and one that will have general appeal—and then we'll talk about getting it published. Before we can decide what makes a good story, obviously we must decide on the audience to which we are appealing. Many a good story has landed in the wastebasket simply because it was directed to the wrong person. I don't think anybody's feelings are going to be hurt if I suggest that the city editor of a metropolitan newspaper is not likely to be passionately interested in the daily routines of institutional housekeeping. But even if the city editor fails to appreciate the beauties of a new method of cleaning rugs, there is someone else on his staff to whom such news may have great interest—and that is the homemaking editor. So why not send it to her?

Let us resign ourselves to the fact that, except in remarkable instances, news of housekeeping activities is far more likely to find an audience on the women's pages of newspapers and in professional journals and women's magazines than it is on the front page of the daily paper or in such publications as *Time, Life* and the *Saturday Evening Post*. There are, of course, exceptions to all rules, including this one. In fact, an excellent story on the activities of an executive housekeeper did appear in a leading national weekly some years ago. It was, in actuality, the story of a spectacular suite—reserved for V.I.P.'s and the very rich—which had recently been opened in a Chicago hotel, but the writer elected to hang it on the equally spectacular personality of the executive housekeeper. It was good publicity for both housekeeper and hotel. Stories of interesting personalities, it might be noted, are likely to make good copy. People always like to read about people.

Another housekeeping story that made a lively and readable feature for a daily paper appeared at the time



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Pandit Nehru visited Chicago and stayed at a leading hotel. Some enterprising reporter got hold of the news that the executive housekeeper was required by the secret service agents responsible for guarding the visitor to select her oldest, most trusted maid to clean the Pandit's suite—and no other housekeeping employes, except, of course, the executive, were permitted to enter it. This story of the precautions taken to protect a guest of the country had an obvious, cloak-and-daggerish sort of appeal, though the housekeeper herself thought the whole thing was pretty silly. After all, she's been playing hostess to all sorts of distinguished visitors for years and couldn't see anything at all remarkable in this episode. It just goes to show that some people don't know a news story when they are making it themselves.

THEY CAN'T ALL BE TOLD

Stories like these don't happen too often in an executive housekeeper's life—and, when they do, most of the time they can't be told! It is a rare institutional housekeeper who could not tell some perfectly fascinating tales about things that happen in her establishment. I have heard quite a few stories that any city editor would give his back teeth to get hold of but the housekeeper who confided them to a reporter would be fired out of hand—and she would deserve to be. Both hotels and hospitals must be constantly on guard to protect the privacy and character of their guests and protect themselves from libel suits.

The question is, then, what *can* an executive housekeeper talk about in public print that is not going to cause anguish to a guest or give away the secrets of the house. Actually, there are many things that executive housekeepers take for granted, because they do them every day, which have great interest for the audience we have selected. And, remember, that audience makes up a very large part of the reading public. You are homemakers on a mass scale; furthermore, your approach to your field is, or should be, much more scientific than that of the average housewife. Your knowledge of cleaning methods, of the chemistry of cleaning compounds, of textiles and fabrics and colors, of interior decoration, of labor saving technics — all these have wide popular appeal.

Another subject with which you are constantly concerned, and which is of equal concern to the public, is safety and accident prevention. Have you ever counted the stories about fires and accidents that appear daily? Well, you spend a great part of your lives trying to prevent just such happenings. Because you are responsible for the safety and welfare of your guests, you have learned to eliminate, or reduce as far as possible, the hazards that cause accidents. Furthermore, you train your employes in the proper methods of lifting and carrying heavy loads to protect them from strains and sprains. And that sort of information is interesting and useful to anyone—no matter how far removed he may be from institutional housekeeping.

Just such a story occupied half a page in the *Grand Rapids Herald* last summer. The title of the story was "Knowing Easy Way to Do Hard Work Is Aid to Homemaker." This is how the story started:

"It all depends on your center of gravity. And, O Yes, there's leverage, too. That's how Sister Mary Mark, physics instructor at Aquinas College, explained a phenomenon which often puzzles hospitalized housewives, among others. 'Many a patient goes home vowing to use the principles of body mechanics which enable nurses to lift and carry heavy objects all day without straining their backs or overtiring themselves,' Sister Mark said.

"As part of her physics courses, Sister Mark teaches the students at the Mercy Central School of Nursing to apply the principles of motion to lifting patients, stooping, carrying trays, and the other potentially back-straining tasks which make up the nurse's day."

That story was about the nursing department, but it might just as well have been about housekeeping. Certainly your employes have to know as much as nurses do about lifting and carrying. It was an excellent story and was illustrated with four photographs which showed how the nurses are taught to lift patients properly. I am sure there were a great many people in Grand Rapids who read it with interest and were grateful for the ideas contained in it. But I'll bet it wouldn't occur to most executive housekeepers that such a story could have the slightest interest for anyone outside an institution.

Another worth-while feature story illustrates the point made earlier that personalities make news. This one was about Dorothy Kalke, executive housekeeper of Milwaukee County Hospital. It described her activities at the enormous county institution and read, in part: "Administrative housekeeping is a rewarding career to Mrs. Erwin Kalke. 'It offers a chance to serve humanity, even though we serve in an indirect way,' she said." The story continued: "The efficient woman is executive housekeeper for the Milwaukee County Hospital. She has been doing housekeeping for the 800 bed hospital on a Paul Bunyan scale for the past 12 years. On her and her staff of more than 100, the institution depends for its physical cleanliness, appearance and maintenance."

THE GOAL OF PUBLICITY

You can't ask for anything much better than that in the way of publicity for the career of executive housekeeping. It seems reasonable to suppose that a good many women, who had never heard of an executive housekeeper or had the faintest idea of what she did, were intrigued by the account of Mrs. Kalke's job and, very possibly, were inspired to investigate the opportunities in executive housekeeping for themselves. That, if I am not mistaken, is precisely what you hope will happen when you get a story about housekeeping in the press.

From what has been written so far, it is apparent that a great many facets of institutional housekeeping can be considered legitimate news for the general public, and the problem is chiefly one of presenting the story in such a way that it will be acceptable to the editors. Our second question is: What information should be assembled? Well, that one is easy: the facts. Whether you are reporting some activity of the National Executive Housekeepers Association or describing a fire safety training program in your own institution, tell your story as simply and clearly as possible. If your institution has a public relations department—or regularly sends news to the papers—the task is made easier. You can mention to the public relations director or the administrator that you think some activity of your department might make a good story and ask if he would like to send a press release to the paper or have a reporter come and talk to you about it. Otherwise, with his permission, you might contact the paper directly. A telephone call to the women's editor, for example, should quickly establish wheth-



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er or not she has any interest in what you have to say. If she expresses interest, you can go ahead and write the story. It doesn't have to be a literary masterpiece, and if your syntax is a bit shaky—don't let it distress you. All publications pay somebody to worry about grammar and spelling. What they want from you are the facts, assembled in a reasonably concise and coherent form.

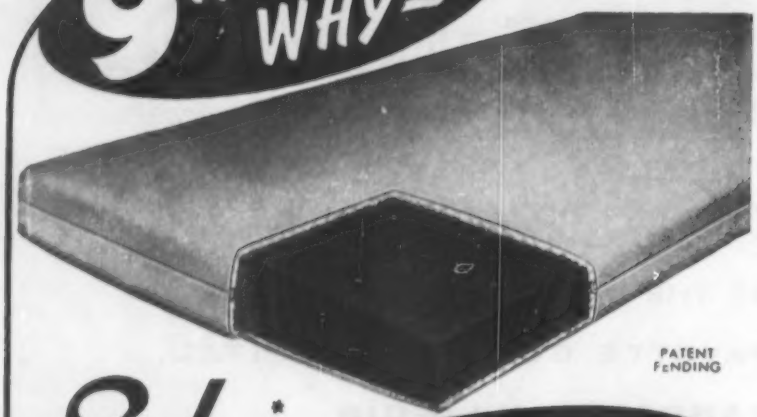
This brings us to the question of how to approach reporters and editors in order to enlist their interest and cooperation. The first job is to make friends with the person who will be handling the story. In this case, I think we have agreed, that will probably be the editor of the women's page, the homemaking editor, the feature editor, or the club editor. These people are not unapproachable at all. After all, it is their job to get good copy. They have to fill a certain number of columns and they are delighted when they have something new to write about. As far as local publicity is concerned, one very good way to become acquainted is to invite the women's editor or a member of her staff to attend a meeting of the N.E.H.A. chapter so that she will have some idea of what your work is and what you will have to say that might be interesting to her readers. You might even go so far as to invite her to dinner. When you do invite the editor to visit you or attend your meeting, tell her what is on your mind and ask her what kind of material makes good copy from her point of view; how you should go about presenting it; what you may have done in the past that was wrong, that failed to get publicity when you had reason to expect that your press release would appear and it didn't.

Newspapers and magazines receive scores, hundreds—sometimes it seems like thousands—of press releases from every conceivable source. The editor's wastebasket is usually very large and usually it is filled to overflowing by the end of the day. In many cases the people who have sent in those releases are hurt and indignant because their masterpieces ended up in that wastebasket rather than in print—and they never know why. Well, the only way to find out is to ask the person who is working with those releases.

The association's contacts with national magazines, in most cases, will have to be established by correspondence. But that is not an insuperable obstacle. A letter outlining an article that might be suitable for a particular publication should at least bring an answer explaining the magazine's needs and policies. If you offer an idea that ties in with the magazine's special interests, you can be assured that the editors will follow up on it and either ask you to write it or send a member of the staff to talk to you. And you needn't be afraid to approach the national women's magazines, such as *Better Homes and Gardens, Woman's Day* or *American Home.* They exist to make the lives of homemakers easier and happier and the chances are excellent that you have many tips to offer that they would be glad to pass on to their readers.

In regard to question 4, the form in which a story should be presented, I can do no better in explaining how to set up your copy and how to time it most effectively than to quote from an article published in The MODERN HOSPITAL two or three years ago by a man who knows both sides of a city editor's desk. In his article entitled "Handle Reporters With Care," Will O'Neil offered the following sound advice which everyone who is trying

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As smart as it is practical, the TOMAC suite of patient room furniture shown above was especially created by Tomlinson for hospitals which want the finest in furniture design and construction.

American Hospital Supply Corporation men who know and understand hospital furnishing problems designed this suite. It was natural that American should want this furniture constructed of native North Carolina black cherry wood with the superior skill that is Tomlinson's after more than a half-century of leadership in crafting furniture of incomparable quality and value.

Ask your American Hospital Supply Corporation sales representative to tell you about the many exceptional features of the TOMAC patient room suite. Or, send a request for more information directly to Tomlinson of High Point, North Carolina.



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to get publicity in a newspaper or magazine would do well to learn by heart.

"Typewritten copy is a must, of course, but the fifth and sixth carbon will not excite the editor's interest. The cleaner the copy, the better it will look to the man who must read stacks of such releases. Always double space—never single space. (Some papers prefer everything triple spaced. Ask the paper.)

"Brevity and clarity are more important than style. The important facts should be summarized in the first paragraph or two. Get to the point, with the explanations, amplifications and qualifications following after. . . . Concentrate on giving the information to work with, rather than a literary masterpiece.

"Good timing can get news in the paper that would never make print otherwise. There are days in the lives of all editors when they need what is called "early copy," *i.e.* items of all lengths that can be prepared and set in type a day or more ahead of publication. The release that reaches the editor's desk 24 hours ahead of the hoped-for printing date has a better chance of getting into print than one that arrives at the last hour.

"Editors almost invariably welcome early copy, two, three, or even four days early, for release in Sunday morning and Monday afternoon papers. The day after a holiday is a good day to shoot for. Saturday papers, on the other hand, are apt to be a little short of space. Timing of copy to hit the paper's soft spots won't guarantee publication of the material offered, but it will improve the chances a great deal. Even if the article is in type and all ready to go in the forms, however, it will be squeezed out if something more important comes along to claim the allotted space. A complaint to the paper the next day won't help any, either in regard to the item that didn't appear or in regard to future items."

APPLIES TO MAGAZINES

Although Mr. O'Neil was writing about newspaper editors, what he said applies equally to magazines. There is, of course, considerable difference in the timing of copy for magazines, which come out weekly or monthly. Sometimes a story has such obvious time value that it must be used immediately. Others are timeless—that is, they can be used at any time without losing their value, so they can be, and often are, held for future use. I may say that delay in publication of an article is baffling and, in many cases, irritating to an author who has worked hard to create it. He just can't understand the callous disregard displayed by the editor in making him wait to see it in print. It *is* unfortunate, and regretted as much by the editors as by the authors, but since magazines must make up their schedules—except for certain last minute copy—far in advance, the delay is really unavoidable. Have patience! If your article has been accepted, it will turn up.

Since I have had no experience with radio and television, I asked a free-lance publicity woman how to approach these mediums. She recommends that anyone who wants to get on a radio or television show use the same approach that he would make to an editor: Get in touch with the director of the show—or, in a small town, the director of the station, and tell him what your idea is and why you think it would be suitable material for his show. Here, again, you must make the approach.

(*Continued on Page* 142)

Where minutes count . . . it's SODASORB 2 to 1!*



*Based on quantitative tests using equal volumes of barium-hydroxide type CO_2 absorbent and SODASORB (Wilson Soda Lime) under simulated operating room conditions.

Complete test data and analysis available upon request.

All of today's CO_2 absorbents are good, but by actual tests SODASORB is twice as convenient . . . twice as efficient . . . as other types of gas absorbents.

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Tests showed that SODASORB has an absorption life of 255 minutes, or more than *double* that of other type absorbents (115 min.). This adds an important convenience to operating room procedure, since canisters filled with SODASORB need be replaced or refilled only *half* as often.

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It takes approximately 20% less SODASORB by weight to fill a canister. Pound for pound porous SODASORB granules go further . . . reduce the ultimate cost of SODASORB to less than one-half that of other type absorbents.

Why not make a CO_2 absorption comparison test of your own? Or have your hospital supply salesman perform it for you. See for yourself why safe, convenient, efficient SODASORB (genuine Wilson Soda Lime) has been universally accepted by the medical profession since 1920.

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Still another means of telling more people about executive housekeeping is the lecture platform. That isn't quite as formidable as it sounds. What I have in mind is not a formal lecture in some vast auditorium, but quite informal talks to civic groups and women's clubs—to which I am sure many housekeepers belong. The members of such organizations would be more interested, probably, than you realize in hearing about your work and the opportunities it offers as a career. Once the word gets around that a speaker from the National Executive Housekeepers Association is available, I think you will be surprised at the number of invitations you will receive from other clubs to come and tell them about your field.

YOU CAN CHANGE THE PICTURE

Your chief problem, it seems, has been that so few people outside your own ranks have any idea of what an executive housekeeper does for a living, and the mental picture that all too many people have of her is something less than flattering. But you will have plenty of opportunities to change that picture if you just let it be known that you are willing to talk. Such an audience as a women's club may not be as large or as widely scattered as the newspaper reading public or a television show, but it is nonetheless worth the trouble of cultivating.

Hospital housekeepers have a special opportunity to reach out into the community via the women's volunteer groups. Only recently the executive housekeeper of a Chicago institution was asked by the members of the women's board to tell them "about her problems." She took them literally and discussed quite a few of the problems that confront the housekeeper in her daily routine — and was highly gratified by their immediate understanding and responsiveness. Some of those women had been serving as volunteers in that hospital for years, yet few of them had more than a vague idea of the importance of housekeeping to the welfare of the patient, simply because nobody had bothered to tell them.

Others with whom you can make rewarding contacts are the vocational guidance counselors of schools and colleges. They are in the business of directing young people into careers, and it would be a good idea to let them know that such a career as executive housekeeping exists. Since your primary purpose in seeking publicity for executive housekeeping is to draw into your field able, well trained men and women, why not go to the source—that is, the high schools and, more especially, the colleges in which you hope some day to see courses in executive housekeeping established? Here, again, you must make yourselves known. Get acquainted with home economics and institutional management teachers and acquaint them with the kind of academic training future housekeepers should have. You can enlist their interest and their help in directing qualified students into your field—*if* they are persuaded that the field offers real opportunity.

In this connection, we received from the Missouri Hospital Association a brochure entitled "Vital Jobs in the Hospital and Allied Health Services." In it a page is devoted to each job performed in a hospital, one of them being executive housekeeping. There is a description of the job, the typical duties involved, education and experience required, registration certificates and locenses required (if any), and the advantages of the job. This brochure has been distributed to vocational guidance counselors throughout Missouri, and the executive housekeepers should be grateful to the Missouri Hospital Association for its enterprise.

By this time, you undoubtedly suspect that I expect you to do most of the work involved in getting the kind of publicity you want. I do. A good news story seldom just happens; it is created by someone who is willing to go to the effort of digging up the news, writing it, making the necessary contacts, and of seeing to it that the story gets to the right person at the right time. Publicity work is hard work, as any professional public relations person will tell you. In this era of press agentry, the competition for space in the press and on the air waves is terrific, and you must face the fact that many of your publicity releases will never see the light of day or, if they do appear, will be brutally cut off at the end of the first paragraph. But don't let it discourage you. It happens all the time—and to professional writers, too.

I have left to the last the kind of publicity which seems to me fundamental to all the rest and which, in the final analysis, will mean more to you than all the press releases, news stories, and television interviews put together. What I am referring to, of course, is the reputation you establish for yourselves—as individuals and, indirectly, for your profession—in your own institutions. What do your guests and patients, your fellow workers, and your employes say about you? If you think nobody knows or cares what the housekeeping department is doing, just let your standards slip for a while. Let your employes be rude to the guests; let the president of the board fall over a mop bucket in the front entrance. You will not be left in any doubt as to how much people know about the housekeeping department and what they think of it—and you.

GOOD NEWS TRAVELS, TOO

Fortunately, news of a good job well done travels just as fast and just as far as bad news does. This was evidenced by an article sent unsolicited to The MODERN HOSPITAL by the nursing arts instructor of Butterworth Hospital, Grand Rapids, Mich., commenting on the series of "Lessons in Good Housekeeping" by Emily C. Deming.

The nursing instructor said, in part: "When one is at the core of a teaching program, it is very easy to become discouraged and feel that nothing is being accomplished. Maybe that is one of the reasons it is so nice to have housekeeping maids around who know what to do and how to do it. You see, I didn't think we could trust them to do it right, and I'm sure this was the thought of many nurses. But, surprisingly enough, we have found that the housekeeping department can now make beds and set up units just as well as the nursing department ever did. This is the result of a successful teaching program, which is an inspiration in itself. . . . Nursing is highly cognizant of the fact that . . . all patient comfort stems from having him, first of all, clean and in a clean comfortable bed in clean pleasant surroundings. Lacking these basic attributes, the success of any therapeutic measures would be doubtful. . . . I feel that we have progressed a long way (or at least I have) when we can safely say as we teach nursing: 'No reasonable request is refused if we call housekeeping or the laundry.' Therefore, if in doubt, 'Call Housekeeping!'"

And that is what is meant by the statement: "Good housekeeping is good news."

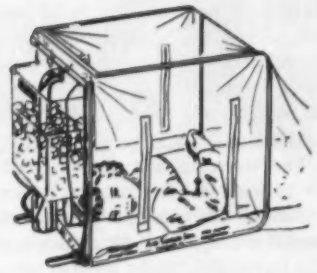
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2. Access to patient	Four side zipper openings	Down from top only	Down from top only	Down from top only	Down from top only
3. Filling of ice chamber	Outside	Inside	Inside	No cooling	Inside
4. Refilling of water supply	Outside	Inside	Inside	Inside	Outside
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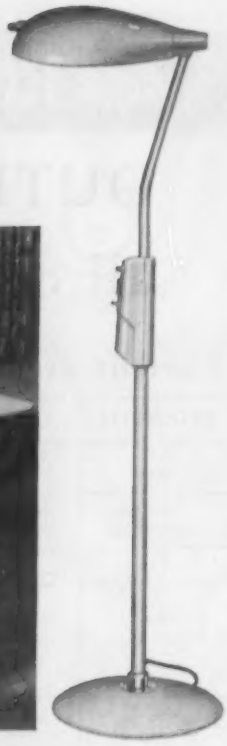
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The convenience outlet on the Hill-Rom No. 306 Lamp is really convenient for the doctor in examining a patient.

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We Need New Patterns of Nursing Care

(Continued From Page 54)

this concept. A staff nurse should be devoting her time mainly to the patient who needs intensive care, and not frittering it away on records and other miscellaneous work. Her responsibilities to the patient who needs relatively little should consist primarily of determining needs and giving leadership to the nonprofessional personnel in meeting them. To achieve this, routine procedures, physical layout, and grouping of patients need to be restudied. Also the curriculum of nursing education should be reviewed. Staffing patterns should be rebuilt around the concept of rendering intensive care to small groups of patients who need it and adjusting the amount of skilled care given to patients with low care needs.

This study showed that approximately nine-tenths of patient care was given by nonprofessional personnel and students. With only one-tenth of it rendered by R.N.'s it is apparent that their ability to administer and to organize the work of other people is of critical importance to good patient care. This means that student nurses should receive a considerable exposure to administrative and organization technics and concepts.

Another finding was the success that some head nurses had in running their units while others were ineffective at arranging their resources for good patient care. It appeared that the successful ones protected their personnel from outside pressures generated by the hospital administration, medical staff, or visitors. Because there is so much tension and pressure involved in caring for patients any increase in it may reduce the effectiveness of some workers. Elimination of as much tension as possible in this loaded situation means that patient care improves through the nurses' ability to plan better, anticipate needs, and provide more adequately for the physical and psychological needs of patients.

The nurse is not really avoiding the patient. On the contrary, nurses as a class are dedicated people who work hard at a difficult job for moderate pay. The factors that hinder them in keeping the total care of hospital patients on a professional level are mainly beyond their individual control. But these problems must be solved if nursing is not to become the vanishing profession.





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The Modern Hospital of the Month

(Continued From Page 60)

the dispatch of the dietary dumb-waiters with patient floor tray receipt and handling. This system makes possible an individual tray time-lapse from beginning setup to patient bed averaging less than three minutes.

Extending the concept of vertical planning, tray return is accomplished with an automatic tray conveyor from the patient floor dietary area. The tray is lowered onto a conveyor series, through the separation areas, and into the dish, silver and glass washing units.

Located at the rear of the first floor, adjacent to the ambulance entrance, are the hospital's emergency facilities, including a fully equipped major operating room.

The hospital's second floor includes induction, surgery, recovery, central supply, pharmacy, laboratories and research sections, the auditorium, x-ray and the family lounge.

The surgery unit provides eight major operating rooms, arranged in pairs with central substerile utility areas, and one orthopedic castroom. The induction area is conveniently located at the cross between the two surgery wings and is adjacent to the surgery control center.

Central supply and the pharmacy similarly adjoin the center, as well as the distribution area, with its supply dumb-waiters, pneumatic tube systems, and other communication terminals.

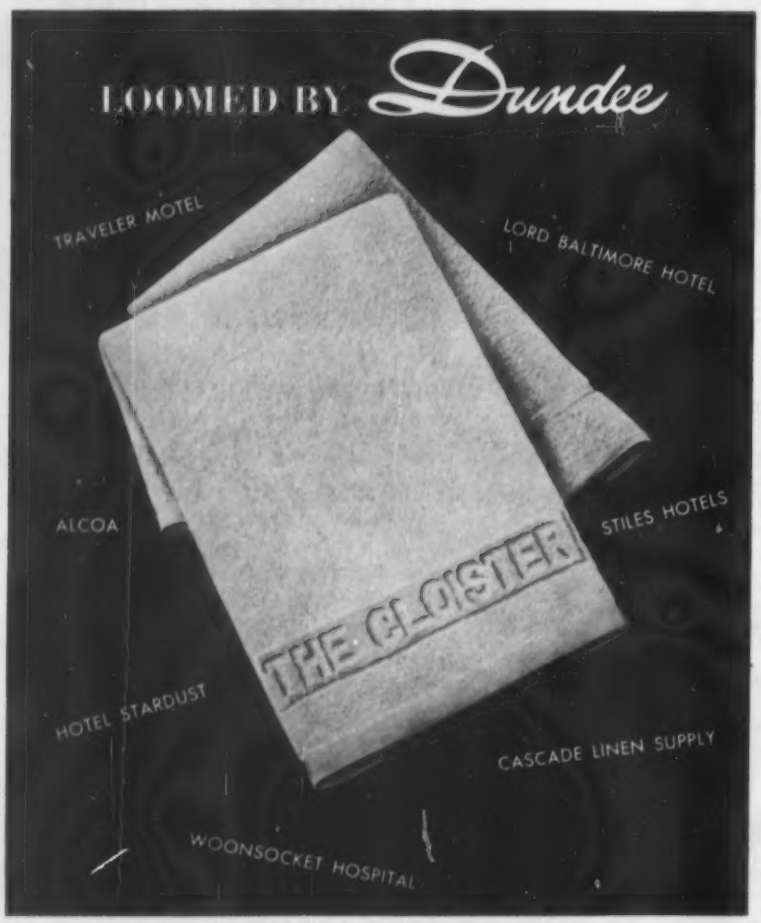
The extended requirements of surgery prompted the separation of instrument preparation from central sterile supply functions, and this is handled by the special instrument prep section adjacent to the center. In addition, the surgical load predisposed the planning of a special room and equipment solely for the handling and preparation of surgical gloves.

Located within the surgical unit, with a capacity of 18 beds, the new recovery division is both unusually large and elaborately equipped. Like the operating rooms and induction area, it is provided with piped-in oxygen, vacuum and anesthetic services to each bedside, as well as fixed, individual sphygmomanometers. The division has its own nurses' center, so placed as to provide continuous surveillance of all beds, and is equipped with an extensive array of special equipment and facilities. The attending nurses are especially trained for, and utilized only in, this work.

A departure from the conventional or anesthesia-recovery concept, this division is in continuous operation, providing its intensely specialized service for hours or days as indicated during the postoperative period. This service, of duration as individually warranted, has the added advantage to the patient of obviating, in nearly all cases, any need for subsequent special nursing when he returns to his room.

Location of the x-ray department is convenient to surgery; in addition to its diagnostic and therapeutic facilities, the department includes one proctoscopic and two cystoscopic rooms.

The family lounge provides an attractive and comfortable waiting area solely for the families of surgical patients. Utilizing a direct communication link with the operating rooms, the hostess relays to the waiting family periodic reports throughout the operation. When the operation has been completed, the surgeon comes to the lounge to report, in person, to the family. Located on the second floor adjoining the elevators, it is in close proximity to and yet sufficiently removed from the surgical unit. To the patient's family, it represents, un-



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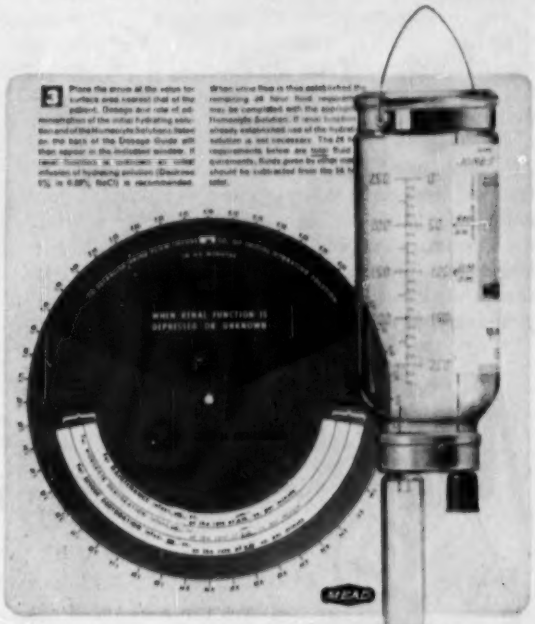
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questionably, the hospital's most appreciated service.

The institution's primary rôle in the various scientific investigations of the Alton Ochsner Medical Foundation's departments of research dictated, in large measure, the size and scope of the laboratory facilities. These, with 25 separate units, occupy 12,000 square feet and represent an investment of more than $600,000. In addition to the customary hospital facilities, the laboratories provide for a variety of special work, including cardiovascular, pulmonary physiology, endocrinology, radioactive isotopes, and the relatively new field of bone pathology.

Also located on the second floor is the hospital's 250 seat auditorium for meetings, seminars and medical presentations. The auditorium and other teaching facilities equip the hospital for its vital rôle in the foundation's fellowship program of graduate specialty training.

An exception to the placement of ancillary facilities on the first two floors is the department of obstetrics, located off the third floor cross and adjacent to the nurseries. The department includes two delivery and four progress rooms.

Each patient floor has two solariums overlooking the Mississippi River, while a special playroom is provided for the pediatric wing. The pediatric unit, an exception to the over-all plan, is served by its own nurses' station.

Each of the 118 patient rooms is provided with toilet and lavatory facilities, including bedpan washing units. Single rooms, in addition, afford bath and shower facilities.

The composite institution, its component areas and facilities, viewed in the over-all perspective, presents a successful translation into reality of a basic motivating philosophy.

It was the intent of the Foundation's trustees to evaluate the cost factors in the primary terms of each area or facility's relationship to the over-all progression of patient care. This basic consideration placed the peak concentration of investment in the area planning and facilities of the surgery unit because it represents the most critical level in patient care. At the next level is the vital recovery division, logically second in cost concentration, and so on.

Simply, this planning concept had as its sought end result the direction of ultimate concentrated investment in terms of ultimate potential benefit to the patient.

CHARGES CORRELATED

A logical correlation is evident in its relationship to the customary progression of charges to the individual patient, declining in direct ratio to the extent and "critical level" of requisite services. This dual gradation in the course and costs of patient care progresses to the routine "room and board" level—and beyond, in the utilization by convalescing patients of the Brent House facilities.

Adjacent to the hospital, the $750,000 four-story Brent House affords modern, hotel-guest accommodations and services which are particularly convenient for the families of hospital patients. Its proximity to the hospital, moreover, offers the patient, as his condition warrants, the option of transition to an "advanced convalescent" level in comfortable guest house surroundings, while such medical supervision as is needed is continued.

Also adjacent to the hospital is the $350,000 Libby-Dufour residence for nurses, affording resident accommodations for 92 of the foundation's nursing staff.

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- No tray completing at serving point! Complete control at kitchen insures dietary accuracy.
- All foods for every tray—special, selective or general diets—are controlled at *main kitchen.* No more *serving* mistakes!
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Cystoscopy Room outfitted with (left) 5H-260 Riverside Duraclay Cystoscopy sink fitted with 8H-70A Dial-ese combination supply fitting and (right) 7H-530 Serval Duraclay flushing service sink with combination supply fitting.



2H-573 Modified Duraclay receiving bath on pedestals, fitted with base and spray. Size 75" long, 30" wide, 5" deep inside. Rim to floor 31".

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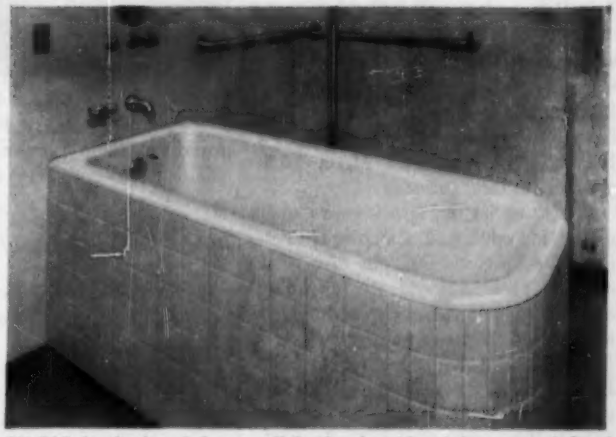
Today's modern hospital requires a very wide variety of *specialized* plumbing fixtures—fixtures especially designed by medical and hospital authorities for specific hospital use.

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When you start plans for your new hospital or hospital addition, don't you think it would be a good idea to discuss Crane with your architect? Chances are you'll find him very much pro-Crane. Most architects are.



2H-565 Institutional free wall bath of acid-resisting enamel fitted with thermostatic mixing valve, vacuum breaker overrim supply spout to guard against siphonage, and hose and spray.





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NEWS DIGEST

Maryland-D.C.-Delaware Meeting Sets Registration Record With 2000 Delegates

WASHINGTON, D.C. — A record registration of just over 2000 delegates at the annual meeting of the Maryland-District of Columbia-Delaware Hospital Association held here November 7 to 9 named Dr. Russell A. Nelson, director of Johns Hopkins Hospital, as president-elect. The opening morning general session featured "Changing Patterns in Nursing Education and Nursing Programs." Sister M. Thomas, R.S.M., administrator of Mercy Hospital, Baltimore, presided.

Charlotte Seyffer, associate professor of nursing education, Catholic University, Washington, D.C., in discussing nursing problems and the changing curriculum, pointed out that the average time a registered nurse practices in Maryland before leaving the field is five years. "Thus," she said, "the cost of preparing a nurse to practice is very high when spread over only five years of actual practice." She urged hospital administrators and nursing education directors to use more material on the principles of management in the nursing school curriculum. Miss Seyffer said that the Good Samaritan Hospital in Cincinnati has revised its entire school of nursing curriculum to condense all of the academic work in two years. The last, or third, year is carried on from an employment basis standpoint with the student nurses averaging a 36 to 38 hour work week with about two weekly hours of seminar classes. These students, during the third year, are paid about one half the starting salary of a registered nurse.

In discussing competition from other sources of employment for women eligible for schools of nursing, Miss Seyffer said, "There are now 400 types of jobs competing with nursing schools. Automation in industry is providing more jobs of a semi-technical nature for young women, thus offering ever increasing competition."

Dr. Walter E. Sindlinger, dean of the Orange County Community College in Middletown, N.Y., described the two-year nursing research program at his college. Dean Sindlinger pointed out that in addition to the students in the experimental two-year program, his college provides clinical and academic instruction for three-year nursing school students from several hospitals in the area.



Retiring President Fred A. McNamara (right center) congratulates the new president, Glenn A. Fisher. Anthony W. Eckert (left) and Ray Brown watch.

Mildred Montag, director, the Cooperative Research Project, Junior and Community College of Education for Nursing, Teachers College, Columbia University, gave progress reports from four or five of the junior and community colleges cooperating on this research project for nursing education.

Irene B. Young, R.N., purchasing agent of the Lutheran Hospital in Baltimore, presided at the purchasing section. Paul Widman, director of purchasing, the Cleveland Clinic and Hospital, was the only speaker at this session. In opening his talk, Mr. Widman said, "A purchasing policy must be determined and put into force by the board of trustees with the help of the hospital administrator and purchasing agent." He continued by pointing out that too few trustees adopt such a policy because too few administrators have recommended and helped in the formation of a good, sound policy.

The trustee section held on Tuesday morning was well attended. William T. Robinson, insurance specialist of the American Hospital Association, reported on the results of an insurance survey conducted by the association in the Maryland-D.C.-Delaware Hospital Association area. Of the 100 member hospitals in this area, 41 returned questionnaires. Thirty-nine of these 41 returns were usable. The one outstanding fact which came from these questionnaires was the inconsistency of insurance practices among hospitals.

Everett W. Jones, a trustee of Provident Hospital in Chicago, gave figures to show hospital trustees the large amounts of working capital which hospitals must have to finance accounts receivable and inventories of operative supplies. "Too few trustees, or for that matter other people in the hospital field, give sufficient thought to the working capital needs of our hospitals," he said.

Tuesday afternoon's general session featured an address by A.H.A. President Ray E. Brown. He said, "Factors supporting my forecast of a steadily increasing cost of hospital operation are built into the nature of the hos-

(*Continued on Page* 160)

A.H.A. Breaks Ground for Headquarters Building

CHICAGO. — Ground was broken here November 9, starting construction of the new 17 story American Hospital Association headquarters building at the corner of Lake Shore Drive and Pearson Street.

Approximately 200 persons attended the ground breaking ceremonies and heard speeches by Ray E. Brown, A.H.A. president and superintendent of the University of Chicago Clinics; Dr. J. Roscoe Miller, president of Northwestern University, and Chicago's Mayor Richard J. Daley.

Ray Brown described the occasion as "an historic moment in the growth of the American Hospital Association and for hospitals."

The building is to be completed in June 1957. Schmidt, Garden and Erikson of Chicago are the architects.

A.H.A. President Ray E. Brown wields the shovel at ground-breaking ceremonies, supervised by (left to right) Dr. J. Roscoe Miller, Chicago's Mayor Richard J. Daley, Rt. Rev. Msgr. John W. Barrett, and Dr. Edwin L. Crosby.





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512545

H.I.A. to Make Annual Award for Contribution to the Hospital Field

CHICAGO. — A speakers' service bureau and an annual award for the outstanding contribution to the hospital field were among the features of a new program announced by the Hospital Industries' Association at a meeting of H.I.A. directors and officers of hospital associations here last month.

The program was described to hospital association officials by J. J. Egan, president, Harry DeWitt, D. R. Zimmerman, Executive Director William E. Smith, and other H.I.A officials.

The proposed speakers' service bureau would develop kits, to be prepared in cooperation with hospital journals, for use by representatives of H.I.A. companies, who would then be prepared to address Rotary Clubs, Kiwanis Clubs and other civic, business and social organizations on the rôle of the hospital in the community.

"The objectives of the speakers' service would be to assist local hospitals in fund drives, nurse recruiting campaigns, and general public relations and good will in cities and communities," an H.I.A. announcement said. "The speakers' bureau would provide authentic information to all speakers. Thus there would be no speaking off the cuff or dissemination of questionable facts or figures. It would be the duty of all speakers representing hospitals to stay within the outline furnished by H.I.A."

As explained by Mr. DeWitt, the proposal for an annual award for the outstanding contribution to the hospital field was to have such an award in each regional area, to be announced at the regional meeting each year. "The recipient may be an administrator, a doctor, an engineer—whoever has made the outstanding contribution to the hospital field," it was explained. "Recipient is to be selected by a committee composed of leaders in the hospital field in the various regions, as well as selected members of H.I.A."

The awards would provide recognition for outstanding service, it was explained, and would also build interest in the regional conventions. "If the idea proves successful on a regional basis, it could be extended and made a national event," Mr. DeWitt said.

Other features of the H.I.A. program for the coming year include development of a speakers' bureau for professional and technical meetings, to provide qualified speakers for hospital conventions on such technical subjects as operating room, laundry, dietary and other technical departments; an incentive award to improve the quality of technical exhibits at hospital conventions, and plans to improve exhibits and attendance at national and regional meetings.

Sister Agnes Elected President of Washington Hospital Association

SPOKANE, WASH. — A talk on accreditation of hospitals by Dr. Jack Masur, assistant surgeon general of the U.S. Public Health Service and a commissioner of the Joint Commission on Accreditation of Hospitals, was a feature of the 23d annual meeting of the Washington State Hospital Association, held here October 19 and 20.

Speaking at the first day's luncheon meeting, Dr. Masur discussed the considerable misunderstanding that exists about the accreditation program—"misunderstanding, I think, on both sides," he said. "Some hospital administrators are not familiar with the real purpose of accreditation. And in some instances, the commission may not be familiar with all the views of the administrators and physicians."



Washington officers, left to right: Max L. Hunt, past president; Sister Agnes, president-elect, and Paul S. Bliss, president for current year.

As a measure of the importance of accreditation, Dr. Masur called attention to the fact that many third-party payment organizations have of their own accord decided to use accreditation as a yardstick in their dealings with hospitals.

At a session on "Better Management," Berl W. Owens, assistant professor, college of engineering, University of Washington, and a management consultant to Seattle's Doctors Hospital, discussed the committee approach to methods improvement.

"For about two years we have been involved in a research program, the major part of which was to determine what industrial engineering technics are appropriate for the hospital," said Professor Owens. "Our observations

(*Continued on Page* 182)

Civil Defense Problems Discussed by Oregon Association Speakers

GEARHART, ORE. — The 22d annual meeting of the Oregon Association of Hospitals was held here October 16 to 18, with a registration estimated at approximately 150; of this number, about 30 were trustees of hospitals.

Melvin Sheflin, executive secretary of the Association of Western Hospitals, announced a second year's grant of $2500 from the Crown Zellerbach Foundation for grants to hospital registered nurses to cover short courses in various clinical specialties. Mr. Sheflin invited hospital administrators of Oregon to submit applications on behalf of some of their nurses for this educational project.

Civil defense was the topic of the opening convention session. Dr. Russell H. Kaufman, president of the Multnomah County Medical Society, president-elect of the Oregon Medical Association, and chief of the emergency medical division, Oregon State Civil Defense Agency, started his discussion with an attack on an article, "Nonsense in Civilian Defense," which appeared in the October 1955 issue of the *Readers Digest*.

Following Dr. Kaufman's presentation, a motion picture produced under the auspices of the Los Angeles County Medical Society, "Flash of Darkness," was presented. This was a dramatic motion picture showing what would happen in a city like Portland, Ore., in the event of a sudden attack.

(*Continued on Page* 186)



Left: Irwin F. Wedel, retiring president of the Oregon Hospital Association, greets Werner W. Hendrickson, new president, and Virginia M. Welch, R.N., who was named president-elect.



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Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. C-4 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y. (In Canada—331 Bartlett Avenue, Toronto.)

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that revolutionized an age-old hospital custom

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California Meeting Has International Flavor

By JOHN GORBY

SAN DIEGO, CALIF.—The annual meeting of the California Hospital Association here, October 26 to 28, was a truly international event. A preconvention banquet given by the mayor of Tijuana, in near-by Mexico, was followed by a real Hawaiian lua on a tropical isle in San Diego bay. However, hula-dancing delegates quickly found there were more serious things afoot.

Dr. Edwin L. Crosby, director of the American Hospital Association, who had just left Washington, informed a hushed gathering that the new Secretary of Health, Education and Welfare feels that there is a possibility of socialized medicine in the United States unless present health insurance plans are furthered. The background for this warning was neatly filled in by George U. Wood, Peralta Hospital, Oakland. Mr. Wood, recently returned from an extended tour of Europe, spoke on "Medicine and Hospitals in Western Europe." He stated that "every government plan for socialization of health services was instituted in a period of depression."

California is determined that it will not be left out in the current national hospital-doctor hassles. Alfred Maffly, Herrick Memorial Hospital, Berkeley, and chairman of the C.H.A. council on professional practice, reported on a resolution adopted by the California Medical Association. Like King Canute ordering the waves to retreat, the resolution urged that hospitals adopt a cost basis for all hospital charges. The delegates, to a man, vowed that they, also, were agin sin and tossed the item to the board of trustees. While the issue has been neatly swept under the rug for the time being, no one believes it will remain there for long. As Mr. Maffly pointed out, the resolution had been printed and widely circulated in the state journal *California Medicine*. Perhaps, he concluded, "we need to tear the Hollywood-type facade from our operations and face realities."

What are we going to do with our senior citizens? Gordon R. Cumming, chief, bureau of hospitals, California Department of Health, tackled this. "We need more nursing homes and convalescent hospitals," he stated. "There is less need for acute general hospitals." Mr. Cumming, who received the association's annual award of merit for outstanding service to California's hospitals at the annual banquet, stated that "people are just living longer than they used to."



California president-elect is Dr. W. W. Stadel (left), with Fred W. Moore, president (right). Standing: Clifton H. Linville, treasurer of the association.

The hospitals of San Diego County, hosts for the convention, received a mild scolding. Ritz E. Heerman, past president of the American Hospital Association and general manager of the Lutheran Society chain of hospitals, was schoolmaster for the occasion. San Diego area hospitals, Mr. Heerman stated, have done a "bad job of public relations. They have not set a pattern of rates that is realistic. Many of them simply can't give adequate care for the fees they charge."

The gem of the meeting was the mock malpractice trial, offered as post-banquet entertainment. Led by the eminent medicolegal expert, Louis J. Regan, M.D., L.L.B., a panel of doctors and attorneys put on a show so realistic that the jury awarded $65,000 damages without once taking their eyes off Dr. Regan. Many valuable tips were dropped during the course of the trial—things we should do and those we should avoid.

The delegates elected a new slate of officers and adjourned vowing to sin no more.

Fred W. Moore, administrator, Rideout Memorial Hospital, Marysville, became president during the meeting, succeeding Paul C. Elliott, Hollywood-Presbyterian Hospital, Los Angeles. New officers are: president-elect, Dr. W. W. Stadel, San Diego County Hospital, San Diego; treasurer, Clifton H. Linville, Fresno Community Hospital, Fresno; trustees, William S. Weeks, Marin General Hospital, San Rafael, B. J. Caldwell, Pomona Valley Community Hospital, Pomona, and George B. Nelson, Glendale Sanitarium & Hospital, Glendale.

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Over-Utilization of Service Provokes Arguments at Nebraska Convention

LINCOLN, NEB.—Herbert A. Anderson, administrator of the Lincoln General Hospital, Lincoln, was succeeded as president of the Nebraska Hospital Association by John L. Hurley, business manager of St. Francis Hospital, Grand Island. Mr. Hurley was installed during the annual banquet of the convention held here October 12 to 14.

Featured speaker at the banquet was Ray E. Brown, president, American Hospital Association and superintendent, University of Chicago Clinics and Hospitals. In discussing decision making problems facing administrators, Mr. Brown sketched the common causes of administrative failure in hospitals. He pointed out that too many people are always trying for the perfect solution, and in their quest for perfection neglect to make what progress is possible at the moment; as a result, they never get anything done.

The Rev. Gerald H. FitzGibbon, S.J., associate professor of philosophy, Creighton University, Omaha, opened the convention with an interesting discussion of "Morals, Mores and Hospital People." Father FitzGibbon said, "Our mores and our morals will determine how we serve our God and our patients and will make or break us as citizens and hospital administrators."



Nebraska officers, l. to r.: John L. Hurley, president; Herbert A. Anderson, past president; Sister Mary Kevin, who was reelected treasurer, and Duane Johnson, president-elect.

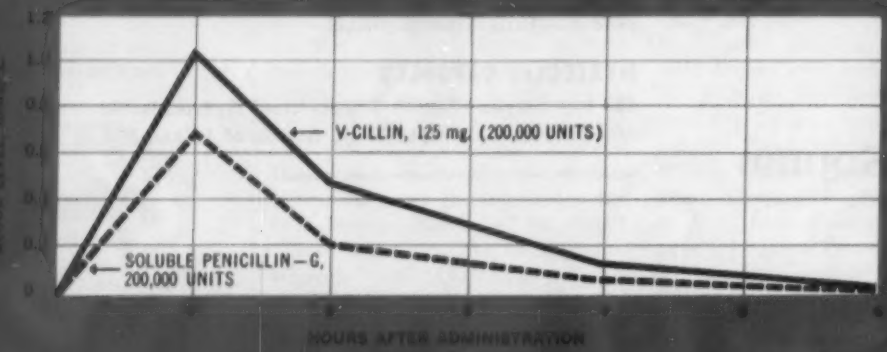
The principal session of the opening morning of the convention was a panel on how to improve patient care, led by Kenneth Williamson, director of the Washington Service Bureau of the A.H.A. This session was featured by a lively discussion on the question of patients being sent in to hospitals as bed patients when they could very well be taken care of at home or on an outpatient department basis. Harold S. Morgan, chief of staff, Lincoln General Hospital, defended the practice of sending in many patients who are often considered candidates for ambulatory care. He said, "Many patients with just common colds get well faster and can avoid complications when cared for as inpatients." Dr. Morgan did agree that there is some unnecessary hospitalization and over-utilization of hospital services for bed patients.

The entire program on Thursday afternoon was taken up by a panel discussion on the economics of financing hospital care. Everett W. Jones, vice president of the Modern Hospital Publishing Company, was the moderator of this discussion. Dr. A. J. Offerman, president of the Nebraska Blue Shield Service, emphasized the public trust aspects of handling other people's money and stressed the principle of service *versus* indemnity types of hospital and medical care insurance. He urged hospital administrators, trustees and staff doctors to conserve the public's money through careful scrutiny of services ordered in the hospital. George N. Mecham, Omaha attorney, discussed the legal aspects of hospital finances and pointed out that the theory of the immunity of charity trusts is being abandoned in many states.

Phil Voght, director of public wel-

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fare for the state of Nebraska, deplored the difficulty of selling the public on accepting taxes high enough to provide sufficient money for adequate medical and hospital care and to pay hospitals their full costs for the care of indigents. He said, "Wherever possible, welfare departments should use voluntary hospital facilities."

The redistricting of the state was discussed at the annual business meeting and the membership voted to try out the new district arrangement for one year and then consider it again at next year's convention. Officers elected during the convention were: president-elect, Duane Johnson, the present secretary of the association and administrator of the University of Nebraska Hospital, Omaha; vice president, Sister Olive Cullenberg, R.N., administrator, the Immanuel Deaconess Hospital, Omaha; secretary, James Kennedy, assistant administrator, Clarkson Memorial Hospital, Omaha. Sister Mary Kevin of St. Catherine's Hospital, Omaha, was reelected treasurer; Gerald Aldridge of Hastings is a new trustee.

Joseph O. Burger, executive director of Nebraska Blue Cross-Blue Shield, was awarded a special plaque of merit by the Nebraska Hospital Association.

COMING EVENTS

AMERICAN HOSPITAL ASSOCIATION, Nursing Service Institute, Minneapolis, Nov. 28-Dec. 2; Personnel Administration Institute, Detroit, Dec. 5-9; Medical Records Institute, Dallas, Tex., Dec. 5-9; Laundry Management Institute, Kansas City, Mo., Dec. 5-9.

FLORIDA HOSPITAL ASSOCIATION, Annual Meeting, Sorono Hotel, St. Petersburg, Fla., Dec. 8, 9.

ILLINOIS HOSPITAL ASSOCIATION, Annual Meeting, Springfield, Dec. 1, 2.

1956

ALABAMA HOSPITAL ASSOCIATION, Annual Convention, Tutwiler Hotel, Birmingham, Jan. 26, 27.

AMERICAN HOSPITAL ASSOCIATION, Chicago, Sept. 15-20.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, St. Louis, Feb. 8-10.

ASSOCIATION OF WESTERN HOSPITALS, Seattle, April 23-26.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke, Va., April 12, 13.

CATHOLIC HOSPITAL ASSOCIATION, Milwaukee, May 21-24.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 26.

KENTUCKY HOSPITAL ASSOCIATION, Lexington, April 3-5.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Convention, Hotel Shoreham, Washington, D.C., Nov. 19-21.

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 10.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Atlantic City, N.J., May 17, 18.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, Mo., April 25-27.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 26-28.

OHIO HOSPITAL ASSOCIATION, Columbus, April 9-12.

SOUTHEASTERN HOSPITAL CONFERENCE, Miami Beach, Fla., April 18-20

TENNESSEE HOSPITAL ASSOCIATION, Hotel Claridge, Memphis, June 21-23.

TEXAS HOSPITAL ASSOCIATION, Dallas, April 3-5.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 3.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 23-25.

WISCONSIN HOSPITAL ASSOCIATION, Milwaukee, March 15.

WORLD CONFEDERATION for PHYSICAL THERAPY, Second Congress, Hotel Statler, New York, June 17-23

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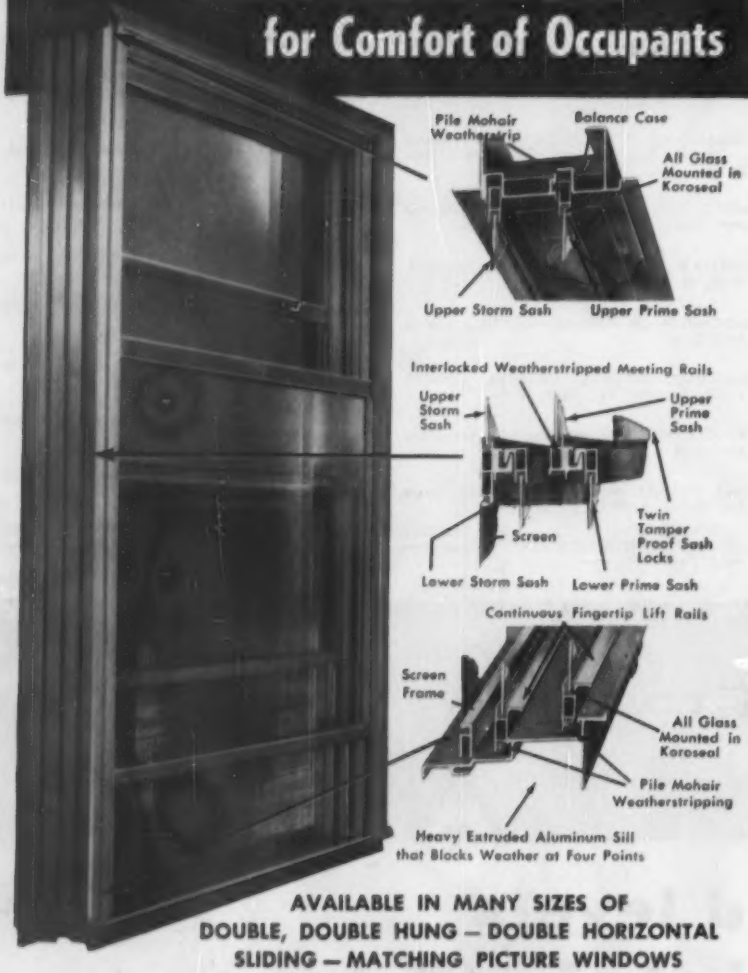
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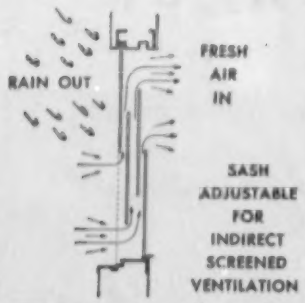
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Maryland-D.C.-Delaware Meeting Sets Record

(*Continued From Page* 152)

pital's operation." Mr. Brown predicted a yearly increase in costs of approximately 5 per cent annually for many years. He explained that hospitals are personal service institutions and "that spells people instead of machines." Hospitals, he continued, cannot reap the economies to be gained from the increased use of machinery or automation. Other industries, however, are increasing their productivity by machines and are able to pay their workers more without increasing the cost of finished products substantially, he pointed out.

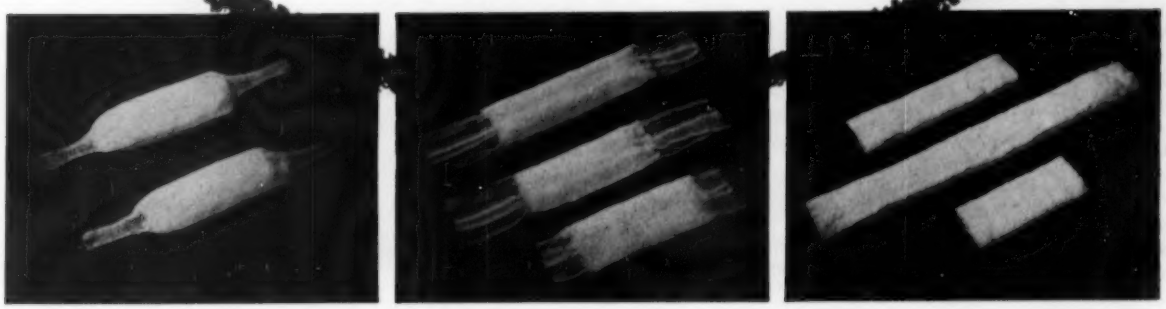
The closing session on Wednesday afternoon was one of the best attended meetings during the convention. The discussion theme presented by Colin Campbell McLean, hospital design and interior decorating consultant of Chicago, was "Today's Hospital Dress." Mr. McLean was assisted by Joe Atkinson, a furniture designer of New York City, and Ben Rose, a designer of fabrics. Mr. McLean said, "At long last the hospital patient is coming into his own. Hospital administrators and their co-workers are beginning to realize that patients must be catered to as we have catered to doctors in the past. Patients want to feel that the hospital is being run for them rather than for doctors and nurses," he said.

President Fred A. McNamara reported to the annual business meeting and commended the board of trustees for approving the employment of a full-time executive secretary. He emphasized the value of such an officer in furthering the development of the association and building worth-while services for member hospitals. During this business meeting Mr. McNamara relinquished the president's badge to the incoming president, Glenn A. Fisher, administrator, Nanticoke Memorial Hospital, Seaford, Del. Other officers elected were: first vice president, Victor F. Ludewig, superintendent, George Washington University Hospital, Washington, D.C.; second vice president, Sister Mary Thomas, R.S.M., administrator, Mercy Hospital, Baltimore; third vice president, Wilbur C. Anderson, executive director, Emily P. Bissel Sanatorium, Wilmington, Del.; secretary, Maurice W. J. Abraham, administrator, Kent General Hospital, Dover, Del.

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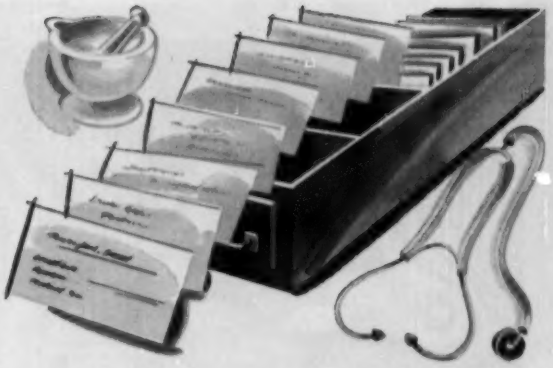
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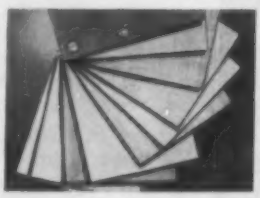
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Hospital Supplier Urges Industry to Make Corporate Gifts to Hospitals

EVANSTON, ILL. — The American Hospital Supply Corporation is sponsoring a campaign to encourage corporate gifts to hospitals as a Christmas observance, it was announced here last month.

In an advertisement appearing in *Fortune* magazine, the corporation suggested that business and industrial leaders send Christmas contributions to hospitals and medical schools in their communities, in place of the usual presents to customers and clients.

Advance proofs of the advertisement were sent to 18,000 hospital people throughout the country, the corporation said.

The advertisement read as follows: "A Christmas Idea for Businessmen: The glorious tradition of giving that surrounds the Christmas season seems to us best exemplified these days by *gifts* to people and institutions that need help.

"Last year, a number of businesses sent contributions to hospitals in their communities in lieu of presents to their customers and clients.

"Won't you consider this simple plan of worth-while Christmas giving this year, and in the years ahead?"

Indiana Association Elects Herbert A. Schacht

EVANSVILLE, IND. — Herbert A. Schacht, administrator of Henry County Hospital, New Castle, was named president-elect of the Indiana Hospital Association, it was announced here last month following the association's annual meeting.

Other officers named by the association were: president, Sister Mary Vetusa, R.N., administrator, St. Catherine Hospital, East Chicago; vice president, Olive M. Murphy, R.N., administrator, Bartholomew County Hospital, Columbus; treasurer, Maude M. Woodard, R.N., Kokomo; executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville; associate secretary, Mrs. Albert G. Hahn, assistant administrator, Protestant Deaconess Hospital, Evansville; trustees, Crayton E. Mann, administrator, Baptist Hospital, Evansville; E. R. Stoner, trustee, Clark County Memorial Hospital, Jeffersonville; Olive M. Murphy; Walter G. Ebert, administrator, Ball Memorial Hospital, Muncie;





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Mother M. Catherine, administrator, Memorial Hospital of Dubois County, Jasper; Sister Mary Reginald, Dyer; delegate, Jack A. L. Hahn, superintendent, Methodist Hospital, Indianapolis; alternate, Ralph M. Haas, administrator, Culver Union Hospital, Crawfordsville.

Colorado Elects Officers

DENVER. — Sister Mary Jerome, Mercy Hospital, Denver, was named president-elect of the Colorado Hospital Association at its 31st annual meeting here last month.

Sister Mary Jerome will succeed John Peterson, Larimer County Hospital, Fort Collins, who became president. Other officers named by the association were: vice president, Hubert Hughes, General Rose Memorial Hospital, Denver; treasurer, M. A. Moritz, Denver General Hospital; new trustees, Louis Liswood, National Jewish Hospital, Denver; Charles K. LeVine, Beth Israel Hospital, Denver; C. F. Fielden Jr., Memorial Hospital, Colorado Springs; Lewis I. Miller, M.D. Delegates to the American Hospital Association were: H. E. Rice, delegate, Porter Sanitarium and Hospital, Denver; Henry Hill, alternate, Weld County Hospital, Greeley.



Sister Mary Jerome



John Peterson

Osteopathic Association Elects Woman President

WASHINGTON, D.C. — The American Osteopathic Hospital Association has elected its first woman president. Mrs. Alixe P. Nuzum, administrator of the Des Moines General Hospital, Des Moines, Iowa, was chosen to head the association at its annual convention here October 31 to November 2.

Other officers elected at the convention were: president-elect, Philip Rosenthal, administrator of Metropolitan Hospital, Philadelphia; first vice president, Heber Grant, administrator, Burbank Hospital, Burbank, Calif.; second vice president, Irvin Biggs, administrator, Rocky Mountain Osteopathic Hospital, Denver; secretary-treasurer, Evelyn Axtell, administrator, Axtell Osteopathic Hospital, Princeton, Mo.

A.O.H.A. trustees elected or reelected were: Lois Beane, R.N., administrator, Bangor Osteopathic Hospital, Bangor, Maine; Sylvia Frumkin, administrator, Northwest Hospital and Clinic, Miami, Fla.; John Zemke, administrator, Mount Clemens General Hospital, Mount Clemens, Mich.; George A. Fuller Jr., administrator, Lakeside Hospital, Kansas City, Mo.; Dr. Merle Griffin, Corpus Christi, Tex.; Margaret Petersen of Albuquerque Osteopathic Hospital, Albuquerque, N.M.

The American College of Osteopathic Hospital Administrators elected the following officers at its meeting just prior to the convention: president, Heber Grant; vice president, A. C. Parmenter, administrator, Still Osteopathic Hospital, Des Moines, Iowa; secretary-treasurer, R. P. Chapman, Davenport, Iowa, and George Fuller, administrator, Lakeside Hospital, Kansas City, Mo., trustee.

R. J. Thomas Heads Virginia Association

ROANOKE, VA. — R. J. Thomas was installed as president of the Virginia Hospital Association at its annual meeting here November 11, 12. Mr. Thomas is director, Grace Hospital, Richmond. The following officers were elected to serve with Mr. Thomas: president-elect, Raymond E. Hogan, Giles Memorial Hospital, Pearisburg; secretary, William R. Reid, Jefferson Hospital, Roanoke; treasurer, George E. Bokinsky, Petersburg General Hospital, Petersburg; trustees, Walter L. Beale, Norfolk General Hospital, Norfolk (retiring president), and John M. Stacey, University of Virginia Hospital, Charlottesville. Homer E. Alberti, Winchester Memorial Hospital, Winchester, and Stuart Aldhizer, Lewis-Gale Hospital, were chosen delegate and alternate, respectively, to the American Hospital Association.



L. to r.: Raymond E. Hogan, president-elect; Robert H. Thomas, incoming president; Walter A. Beale, past president, Virginia Hospital Association.



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#1006 High back chair



#7001 Over-bed table

#803 Bed

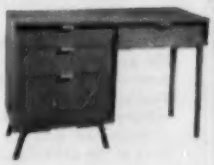


#701 Footstool



#824 Bedside-Chest

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A.C.S. Clinical Congress: Surgeons Study Infections in the Operating Room

(*Continued From Page* 51)

pitals. He said fellows of the college were not encouraged to operate in nonaccredited hospitals and emphasized the importance to the public of the hospital accreditation movement.

In his annual report to fellows of the college, Dr. Paul R. Hawley, A.C.S. director, said that fee splitting must be stopped if medicine is to continue as a free profession. "If the profession does not stop it, the public will," Dr. Hawley declared. "However, this problem has become so great, involving forces which are beyond the ability of the college to cope with, that the college cannot solve it alone. Attacking this evil solely by expelling fellows who are caught engaging in the practice is like attacking the problem of alcoholism by arresting a few drunks.

"We can continue to temporize and to appease, or we can make an issue at once. However, from all indications and from recent experiences, it is an issue which must be taken to the public."

In another major address to the congress, Dr. Grayson Kirk, president of Columbia University, New York City, told the assembled surgeons that the quality of medical education and medical care for the future are being threatened today by abandonment of the principle of full-time teaching and research in medical schools, and by overemphasis on specialization.

"We must have men of dedication not to income, but to humanity," Dr. Kirk declared, warning that too many medical teachers were unwilling to remain on full-time salaries in the universities and were turning to private practice, with its greater financial rewards.

FULL-TIME TEACHING

The greatest achievements of scientific medicine were made possible when our medical schools adopted a principle that made competent teaching and rapid progress in research inevitable, Dr. Kirk stated.

"I refer to the decision to establish clinical departments on the same full-time teaching basis as the scientific departments," he said. "No greater single step forward has ever been taken in American medical education.

"Full-time teaching and research were made possible because there were men who were devoted enough to forego the pecuniary advantages of a part-time teaching career and to spend their lives in the pursuit of ideals other than income," he said.

"Let me put the matter in the form of a question," he added: "Is your profession in danger of yielding overly much to the allurements of income? It is for you, not for me, to answer such a question. But if the answer should be affirmative, it would help to explain some of our recruitment difficulties in the educational system."

A proper balance between breadth in education and the ever increasing demands of professional specialization must be maintained in medical schools, the speaker said.

"If the present generation digs ever deeper into narrowing grooves of specialization, we will have a great variety of highly skilled technicians, but we may not have enough men with that breadth of view which alone can give direction and meaning to scientific endeavor," he explained. "In an age of specialization, wisdom must still rule, whatever the specialist's activity and interest."

SURGICAL PHYSIOLOGY

Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois, was installed as president of the college at the annual convocation, succeeding Dr. Alfred Blalock of Johns Hopkins University, Baltimore.

Improved mortality records for many surgical operations today compared with mortality rates a generation ago are not all due to improved surgical technics, Dr. Cole said in his presidential address, delivered at the convocation. In many instances, improved performance is attributable to better understanding of surgical physiology, he added.

"We have learned that we must not do major operations on patients with dehydration, electrolyte deficiency, anemia or malnutrition until corrective measures have been utilized," he explained. "Years ago, patients with cancer of the stomach were sent to the operating room without any preparative preparations except for administration of a generous amount of a saline purge which unfortunately added to the patients' dehydration, electrolyte imbalance and malnutrition.

"We can still profit more than we have from the lesson just mentioned, insofar as we should inquire from every



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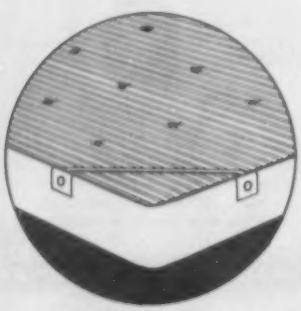
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patient about to have a major operation, particularly one involving the intestinal tract, how much weight he has lost during the few weeks previous to the contemplated operation, and what his food intake has been.

"It is not sufficient to know that the patient has been eating three meals a day; we must know whether they were full meals, only half, or even less. A few days' therapy with high caloric intake supplemented perhaps with intravenous fluids including blood will help tremendously, because the depleted human body undoubtedly knows where to put the protein molecules where they will do the most good."

SURGICAL DEFICIENCIES

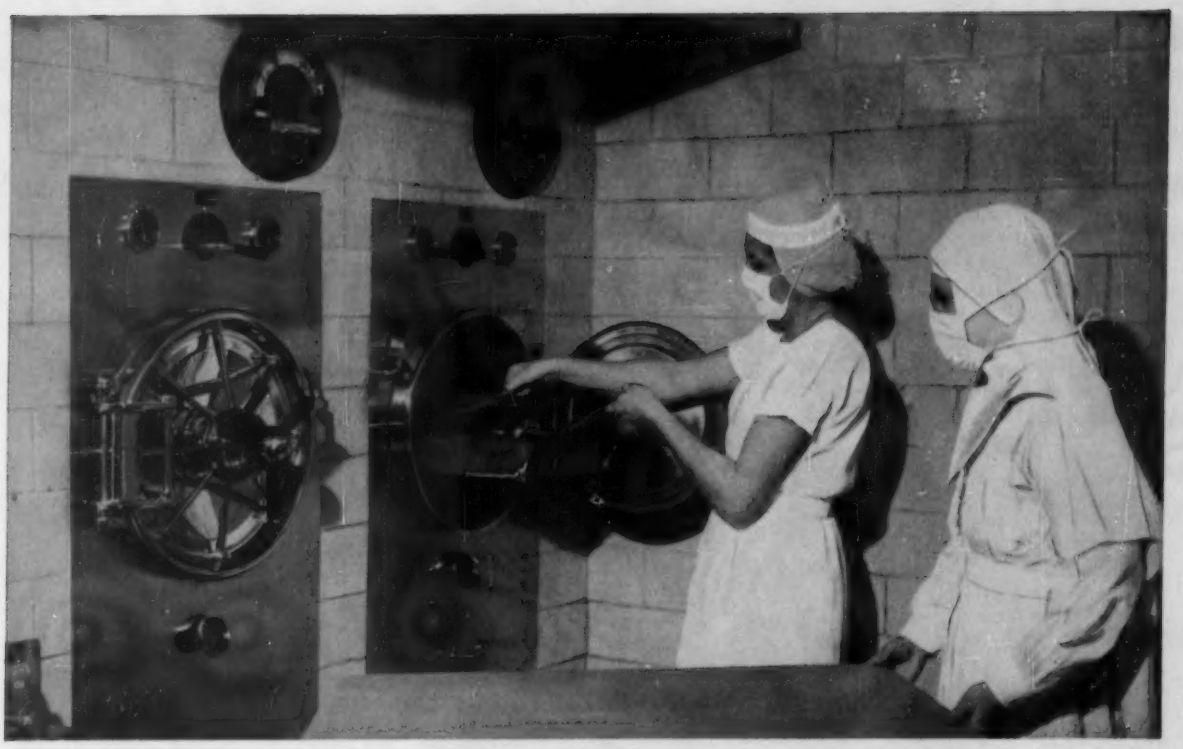
The American system of training surgeons through hospital residencies is the best system existing anywhere today, Dr. Cole said. Nevertheless, he warned, American surgeons must be alert to the danger of retrogression in surgical standards.

Among the "serious deficiences" in today's surgical standards, he named low standards in traumatic surgery: "In case you do not fully appreciate the seriousness of this deficiency let me ask you this question: Suppose you, or a member of your family, had a serious accident out in the country, too far away, or injury too severe, to allow transportation to a medical center, would you be concerned about the standard of treatment you would receive?

"By this question I am not identifying any particular group of physicians as being incapable of caring for the injured person, because far too many qualified general surgeons themselves have inadequate knowledge of the diagnostic and therapeutic features of trauma.

"This sets the stage for confusion of effort and efficiency unless the physician in charge is well qualified in various aspects of trauma, and able to recognize danger signals in all areas of the body. All physicians during their training, particularly surgeons, should have more of their training period devoted to a study of the injured. Trauma is a field where the specialty bars should be modified in that each specialist should study trauma in other specialty fields."

Dr. Daniel C. Elkin, Emory University, Atlanta, Ga., was named president-elect of the college. He will succeed Dr. Cole at the clinical congress in San Francisco next October.



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The photographs here show recent Castle installations at Chicago's new Resurrection Hospital . . . the 3-minute unit, top right . . . a 30-minute unit, top left . . . a Nickel-Clad Steel bulk unit in the small photo. Examine them closely. Notice the self-centering doors, the easy-to-use, clear reading Thermatic Control. Notice, too, the Monel trays.

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Dietitian as a Buyer Takes A.D.A. Spotlight

(*Continued From Page* 120)

bills to permit discounts. Selective menus go to all patients at St. Luke's.

At another conference on the selective menu, Grace E. Brazzale of St. Luke's Hospital, Milwaukee, reported the use of a four-week master menu plan. This calls for generic terms on the daily selective menu and for ward use ("green beans" rather than "fresh" or "frozen," and "melon" rather than "cantaloupe") to permit flexibility in meeting market fluctuations and availability. At her hospital the selective menu appears on the breakfast tray the day before the selections are served. Additional copies of the selective menus are left on the floors for late admissions other than surgical. These are followed through by a dietetic aide or clerk. All dishes are stated in simple terms so that the patient has an inkling of what he may expect. Gravy and potato are listed as separate items, for instance, since some prefer potato gravy-less. All patients on therapeutic diets are visited daily for assistance in arranging their selective menu. All receive a copy of the "Basic Seven," and starred items appear on selective menu to aid in making wise selections from a nutritional standpoint. No charge is made for special instructions by the dietitian when the patient leaves the hospital.

In fact, there seems to be an increasing hesitancy on the part of dietitians to make the many small extra or "nuisance" charges so common in other departments of a hospital. Such practices, they feel, are contrary to good public relations. Moreover, the cost of processing these items makes the system unremunerative and strictly a nuisance for all concerned.

Mrs. Brazzale reported that 33 per cent of her patients are on special diets whereas 25 per cent is the more usual figure. She cited one hospital that offers a selective soft diet. The summarizing of selective menu slips in a 175 bed hospital requires about one hour's work by diet clerks, she reported. Few hospitals are grinding meats on the soft diet; "any type of meat that can be cut with a fork" is being used instead. The use of precut frozen meats is especially conducive to economy and convenience on the selective menu. With ample deep freezer space the problem of waste resulting from fluctuations in census is largely obviated through sharp freezing of leftovers.

In-between nourishments, long a bane of the dietitian, are now being generally discouraged except where there is a definite therapeutic need. However, Mrs. Brazzale reported that the patient may get items from the coffee shop if given an authorized slip. Twenty minutes before serving time the dietitian calls the floors and asks for new admissions or discharges.

A showing of hands indicated that none of the group is using the selective menu plan offered in one leading hospital publication or somewhat similar devices used by other magazines. (This may only mean that the group was not fully representative of all areas in which such help may be most welcome.) Another interesting sidelight was that men's wards are served before women's wards because "men are more prompt than women in preparing for meals."

Repeatedly it was stressed that labor costs rather than food costs need major attention; hence, the space devoted on the program to time and motion studies, supervisory technics, kitchen plans for greater efficiency,



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and labor schedules. To determine the selling prices of dishes primarily on the basis of raw food cost is no longer realistic; the markup is rather on the basis of preparation time, that is, labor cost involved.

In prefacing his remarks on time studies in food preparation, Harry H. Pope, president of Pope's Cafeterias, St. Louis, said that the "most important contributions to the food industry have come from the dietitians." This graceful compliment fell pleasantly on the ears of the assembled hospital dietitians, many of whom, however, would be the first to admit that the profit-making public eating place has a stronger motivation toward good business procedures than has the usual altruistically-minded hospital. (The hospital dietitian often "inherits" old retainers long in the hospital service with whom the use of time studies requires great discretion, to put it mildly.)

"Time studies," said Mr. Pope, "usually show that most kitchens do not need more *labor saving"; instead what they need is better utilization* of the labor available. In industrial engineering terminology the big source of labor loss in food preparation is due to "observation time" and "waiting time." The cook's hands are idle as he "watches" or "waits" for the potatoes to boil, the roast to roast. Since it is indisputable that the ingredients used in a menu item are to be weighed or measured, why not measure also the labor used in producing the item? The employe may be reassured if you tell him you wish to make certain he is not overworked or perhaps that you wish to establish a fair pace for each job. This last in substance *is* the first objective in time studies.

Production time of menu items produced without interruption—most salads and sandwiches, for example—is most easily measured. In time studies of items prepared in steps, Mr. Pope said, record *only* the time a food item is actually handled. During the cooking time, unless stirring or constant watching is required, no labor is involved.

Time studies encourage greater labor efficiency, give the production supervisor an accurate method of evaluating the employe's ability, and, if an incentive system is used, serve as a good basis for rewarding efficiency. Only through time studies can it be determined whether it will pay to buy potatoes peeled or unpeeled, meats precut or otherwise. Comparison of time studies with accepted standards for a like menu item will determine the level of efficiency for the whole operation, Mr. Pope declared.

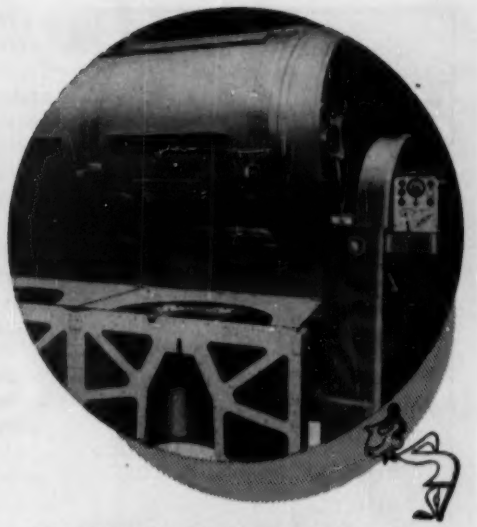
In discussing "dollar sense in buying beef," Capt. Marian J. Hayton USAF (WMSC), food service officer at Wright-Patterson Air Force Base Hospital, pointed out the considerations that determine whether carcass, primal cuts, or fabricated beef is the best buy. If she buys carcass or primal cut, the dietitian should not forget the dollar value of the remaining items once she has used the top round and rolled rib for which the order may have originally been placed.

Captain Hayton's calculated costs per portion were compared according to grades and methods of purchase, with some unexpected results. Portion cost of top round from fabricated beef was appreciably less than that from carcass and primal cuts; of rolled rib from primal cuts, considerably less than that from carcass or fabricated rolled rib. Results from a comparison of portion costs among the three methods of purchase indicated that no one method is most advantageous for institutional use. Purchase price per pound is not an accurate index of cost per portion.

In a discussion of labor hours in the dietary department, Beatrice Donaldson of the University of Wisconsin said that head dietitians have recognized the currently urgent need to analyze labor costs in order to keep expenditures within budgeted limits. While labor costs usually are less variable than are food costs, it is a generally accepted fact that the so-called "hidden costs" of labor are as significant as those of food. Percentage expenditures for food not only have been calculated regularly but have been divided into groups for the purpose of analyzing expenditures more specifically. There is like need to do this with labor costs, Dr. Donaldson said, so that figures will indicate what part of the labor dollar goes for preparation, service, cleaning and other areas involved. Such analyses on a percentage basis can give a fairly comprehensive view of labor productivity in the dietary department.

Comparative labor costs are not too meaningful, however, since wage scales and working conditions vary. Better a report of labor *minutes* per meal and an analysis of percentage distribution of labor time as a basis for determin-

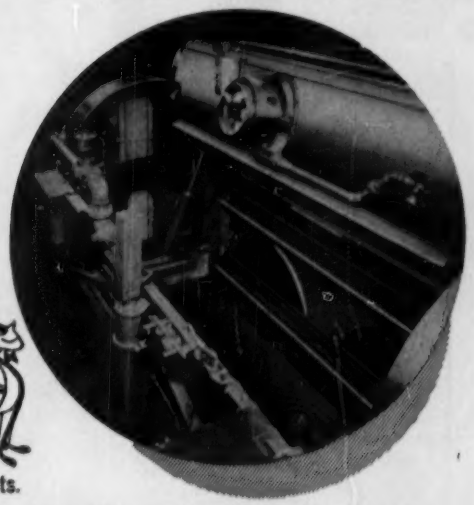
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ing hidden costs of labor and for comparison with similar departments elsewhere. The many variables such as equipment, type of menu, and type of service can also indicate factors that may limit efficient food production in a given unit. A group of 200 to 299 bed hospitals, for instance, showed a range of from one to eight dietitians employed. Labor time per meal declined proportionately as number of meals served increased.

It would seemingly take the space of "Encyclopaedia Britannica" to cover the usable or thought-provoking ideas arrayed at this convention. The program was overwhelming. The usual number of doctors of philosophy—in psychology, in business management, in food technology, in general institutional management, in sales training, in educational philosophy, in behavioral studies, even in communications and skills in speech—daily assailed the ever-resilient dietitians with ideas which they, the doctors of philosophy, had at least had time, we trust, to bring to a satisfactory fulfillment. Yet some knowledge of all these special skills, so ably presented, is increasingly demanded of today's dietitians.

Then there were the R.N.'s and the M.D.'s: How shall we cooperate effectively with state leagues of nursing and boards of nurse examiners? What is the latest, not necessarily the *last*, word on the dietary management of renal lithiasis, food intake and hypnosis in surgical diseases, diabetes and overweight, new and improved plants for human use, dietary lipids and blood coagulation, exposure of food to nuclear explosions or nutrition under survival conditions? And what about niacin deficiency in man, or endemic cretinism in Europe?

The dietitians found that there are still newer findings on the amino acids, that there probably *are* more vitamins, that even the "Basic Seven" is being torn apart for "suggested" revisions or at least regrouping. Withal, the dietitian must maintain a balanced point of view so that she may continue combating the food misinformation of her public.

Various means were offered to keep the dietitian from spreading herself too thin over her scope of responsibilities. A psychologist discussed a rating form for staff dietitians, to make the dietitian aware of those areas in which she needs improvement, and to suggest ways to attain this improvement, all of which would lead, *Deo volente*, to a happier and easier load of supervisory duties and, hence, more effective supervision. (Sounds like a good idea especially if the hospital patients and personnel could fast one day a week to permit the chief dietitian to catch up on her paper work, the heavy load of methodology which threatens to engulf her.) With the steady improvement in the college and internship training of the dietitian and with the increasing demand for these already "well rated" but all too scarce dietitians, what appeared to the convention-goers as most needed is a practical means of developing the supervisory capacities of nonprofessional employes.

In a program aptly titled "Stretching Our Services," Elizabeth Perry, assistant superintendent and chief dietitian of Cleveland City Hospital, one of the originators in the training of food service supervisors, spoke with authority on the subject. Her training is planned on the basis of the educational background of the students, usually high school young people. It is important that they be viewed as students rather than employes during their on-the-job training, she said.

"Skilled supervision is the ability to assume responsibility, to teach, to show leadership," Miss Perry declared. "When training is completed, give the graduate a job and the responsibility she has been trained to carry," Miss Perry declared.

Mary Zahasky of the University of Oklahoma Hospital had a somewhat different approach. There some of the more promising employes are trained as "dietary assistants" and given slight increases in salary. These graduates now assume some of the routine duties of the professional staff who, as a result, have more time "to investigate, to evaluate, and to plan for better operating units and better teaching experiences."

Tying in with the foregoing were some statements by Lucille Refshauge, director of dietetics of Hartford Hospital, Hartford, Conn., the association's president-elect. Speaking on "New Trends in Administration of the Food Service," she said dietitians are inclined to see certain personnel fixed in definite positions and duties. "When making a personnel inventory, ask yourself 'What unused capacities haven't been tapped?' and 'Are all personnel assigned to jobs corresponding to their ability and skill?'" Miss Refshauge suggested. She believes the die-



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titian must now relinquish many duties she should have given up long ago—"nonprofessional" duties. Success in the delegation of such duties calls for "concise procedures and written instructions for the service of food; this affords the dietitian's touch where auxiliary workers are used extensively." She suggested panel tasting, scoring of food, and other devices to help the food supervisor meet the specific *expected* standards. In Connecticut's training program, under the auspices of the state's dietetic and hospital associations working with the state's department of education, trainees are now on a six-month rotating service with assignments in designated hospitals. Some are outside recruits but most are regular food service personnel who wish to improve their status, she explained.

Miss Refshauge's department diet manual serves as a guide to all concerned. It defines procedures, requests specific prescriptions, facilitates modification of diets.

"Kitchen layouts change slowly," said one male member, Lendal H. Kotschevar, Montana State University. Margaret Terrill, University of Washington, said the food industry has not made progress in the equipment field in keeping with other industries. At the same session Leslie W. Scott, Michigan State University, declared the food service industry needs to design and devise more equipment that will effectively reduce the number of employes in both preparation and service. In illustration, he cited the new tea urn that automatically brews a liquid concentrate of tea that is combined with a measured amount of hot water at the spigot—as simple as a coffee urn. New methods of quick cookery reduce overall production time more than 65 per cent, hence will reduce some of that expensive "watching and waiting"—hidden costs on the production line.

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The room station is operated by pulling a cord. This closes a concealed switch, lights the white "calling" light at the room station, the corridor light (not shown) over the room door, a sectional light at the corridor intersections, and the light at the nurse's station annunciator (see below) to indicate which room is calling. In addition to the light at the nurse's station, an audible signal is sounded to let the nurse know that a patient is calling.

To answer the call, the nurse picks up her telephone hand set and is automatically connected to the patient for two-way communication. Simultaneously, the calling station is reset, a green "connection" light at the room station is lit, and the white "calling" light and the corridor lights are extinguished. This indicates to the patient that the nurse is connected to the room station and normal conversation may take place.

The room station can be manually reset. (If the nurse observes the corridor light, she can step into the room, reset the station manually and attend the patient without returning to her desk.) The nurse can answer in sequence automatically or in any order manually two or more simultaneous calls. Any room station can be monitored from the nurse's station.

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NEW OFFICERS

At the banquet session Winifred Howard Erickson, director of the department of dietetics at Ancker Hospital, St. Paul, took office as president. Other new members of the executive board are: president-elect, Lucille M. Refshauge; speaker of the house of delegates, Marguerite L. Pettee, nutritionist, University of Colorado Medical School, Denver; treasurer, Doris Johnson, director of the department of dietetics, Grace-New Haven Community Hospital, New Haven, Conn. Mary Ellen Johnson, education director of dietetic internship, Colorado State Hospital, Pueblo, retains the post of secretary for the coming year.

The Marjorie Hulsizer Copher Award, highest honor conferred by the association, was given to S. Margaret Gillam, now a dietetic consultant. Miss Gillam was the American Hospital Association's first dietetic specialist and was a former A.D.A. president. Her citation read as follows: "In recognition of her great contribution to the scientific and professional stature of her chosen profession, through her innate talent in the art of food preparation and service, through her demonstrated excellence in planning, organizing and operating hospital dietary departments and approved dietetic internships, and through her energy, ability and devotion in translating her experience for the general benefit of all dietitians and nutritionists."

The presentation was made by Dr. F. R. Bradley, director of Barnes Hospital, St. Louis, with Marjorie Ann Copher, daughter of the late Mrs. Copher for whom the award is named, in attendance.



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Conclude Hearings in Iowa Lawsuit

(*Continued From Page 72*)

hospital. And the better, the stronger we have the hospital and the services it can offer, the efficiency that the hospital has, the better job a doctor can do."

Dr. Snoke testified that the relationship between hospital and medical specialists "has developed through a trial and error basis, and I think it has developed through what seemed to make sense in the local areas."

He added: "I think it is extremely important to emphasize that today throughout the country there are varying patterns that you can find vigorous proponents of, and yet they are diametrically opposed. And the reason they think they are good is because they are working. And I think that the patient is benefiting by this flexibility."

Dr. Snoke was asked if he thought only salaried physicians should work in hospitals, and he replied:

"Oh, no. No. I think that is absurd."

He added, however, that the pathologist, radiologist and anesthesiologist "are a little bit different as far as the hospital and its organization and the practice of medicine are concerned than are clinical surgeons, internists and so forth. So I think that perhaps one can develop an argument or justification for some type of salaries or fee for service for them."

He testified that there is "not the slightest" ethical restriction against a physician accepting a salary from a hospital.

Referring to a key issue in the lawsuit, Dr. Snoke testified that "the method of payment as a determining factor of the legality of the practice of medicine just seems silly to me."

He added: "Never have I been able to have it demonstrated to me that the care of the patient can suffer under the salary or fee for services or commission methods of payment."

He said arguments that hospitals, in seeking to retain operation of their laboratories, hope to take over the general practice of medicine were "completely and utterly nonsense."

He added:

"I just can't conceive of a hospital practicing medicine. The doctor practices medicine in the hospital."

Dr. Snoke recognized that another purpose of the trial was to arrive at a legal definition of hospital and medical services for the guidance of various hospital and medical insurance plans. He testified:

"If all of the medical services in a hospital such as pathology and radiology and anesthesiology and physical medicine were taken from the Blue Cross plan, it would be only a plan for bed, board and nursing care.

"I feel if this were to happen that the attractiveness of the Blue Cross plan to the public would deteriorate, and this would immediately injure the Blue Cross plans and the hospitals immeasurably.

"Frankly, and this is my own opinion, it is my personal feeling that I don't think the Blue Cross and Blue Shield plans should be competing. I think they should combine into one plan and offer one plan to the public and not be in competition among themselves."

Near the conclusion of his court appearance, Dr. Snoke testified:

"I have been concerned over the future of hospital-physician relationships, regardless of what decision is made by Judge Moore in this debate and argument. So much emotion has gone into it, and so much exaggeration, and I think we have built minor things



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or minor points into larger points, and I think a lot of hurt feelings have occurred.

"Whatever decision is reached . . . the hospitals and the doctors have got to live together.

"And this is the thing that bothers me tremendously—the being able to work together toward a common goal with this continual ferment. I hope, however this decision comes out, that some way of getting together can be developed."

Another witness for the hospital association was James A. Hamilton, director of the course in hospital administration at the University of Minnesota and a past president of the A.H.A.

Discussing the effect of the opinion rendered by the Iowa attorney general that hospitals legally cannot hire medical specialists and charge patients for their services, Mr. Hamilton said the enforcement of the opinion "could be a very dangerous thing" because trustees and private contributors to nonprofit hospitals "might diminish their support" if they felt they were donating "even indirectly" to the private gain of such medical specialists as radiologists and pathologists. Withdrawal of such support could lead to the "disintegration" of the nonprofit hospital, he added.

If hospitals were divided by leasing departments to pathologists and radiologists, "you'd be disturbing the basic reason for having the hospital there in the first place," Mr. Hamilton said.

The closing arguments of Iowa Hospital Association attorneys at the end of the long trial reflected the opinions of Dr. Snoke and Mr. Hamilton.

Judge Herrick opened the arguments by stating:

"The issue in this case is whether some 170 nonprofit hospitals in this state shall be permitted to continue operating laboratories or whether the hospitals are going to be directed to surrender these laboratories to a small group of medical experts."

Compliance with the Iowa attorney general's insistence on a space-lease arrangement between specialists and hospitals, Judge Herrick said, would "put the hospitals in a legal and economic strait-jacket" that would "mean the beginning of the disintegration of the hospital."

The hospitals' operation of those laboratories for over 30 years, he added, was "strong evidence" that the operation was legal. He argued that pathologists had a "financial motive" in seeking a change in these long-standing arrangements.

Mr. Langdon argued that radiologists and pathologists "don't have that final, ultimate, vital responsibility for deciding what should be done with the patient" in a hospital.

"In other words," he said, "they're doctors' doctors" and it is "perfectly proper" for hospitals to furnish their services to attending physicians.

Both Judge Herrick and Mr. Langdon pleaded with Judge Moore to place a "practical construction" on Iowa's medical practice act, which governs the purveyal of medical services.

Mr. Langdon argued that "the only real prohibition" of the act "is the selling of medical services by a corporation for a profit."

Mr. Langdon insisted that "the charitable, nonprofit hospitals . . . are not furnishing or selling such services for a profit [and so] are entitled to be exempt from any prohibition of the medical practice acts." He concluded that pathology and radiology are "fundamentally, historically and universally throughout the country considered to be hospital services."



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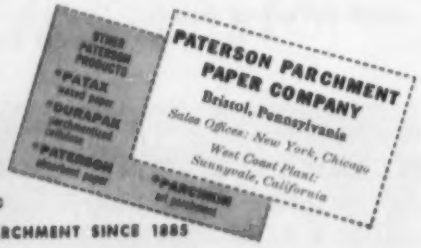


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Washington Association Elects Sister Agnes

(*Continued From Page* 154)

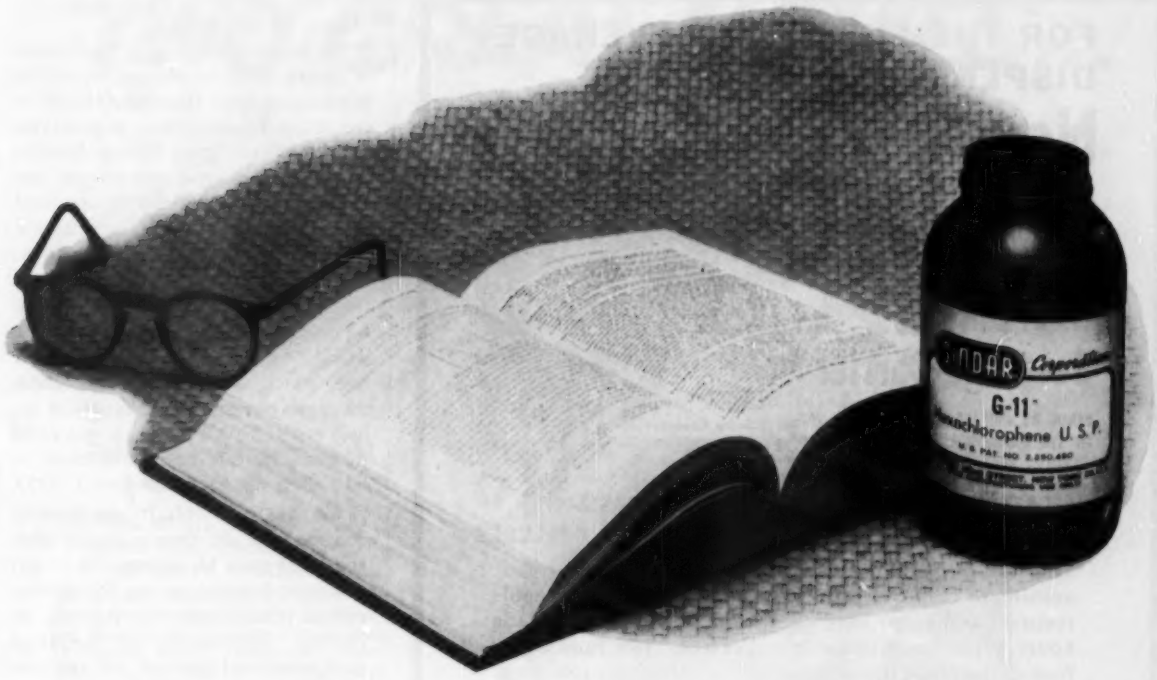
during the study led us to believe that a formal program is equally worth while in small hospitals. We recommend that every hospital with 100 beds or more undertake a methods improvement program."

Theodore J. Barnowe, professor of human relations and administration, college of business administration, University of Washington, discussed the general problem of administration of the hospital and the nursing service. He asked: "Why, with so much excellent material published on administrative technics and the interdependence of good human relations programs with top administration, are so many mistakes made by managers, executives and administrators, not only in hospitals but also in the industrial and business fields? We are a very 'shouldy' people. We are always saying *we* should or *you* should do this or that."

The speaker pointed out that instead of telling people what they should do, we should attempt to draw out from our supervisors and employes their own thoughts as to what ought to be done.

Clarence M. Pritchard, chairman of the state hospital licensing advisory council and administrator of the Central Memorial Hospital, Toppenish, Wash., reported on what's ahead in state licensing of hospitals at the afternoon session. In reporting on this subject Mr. Pritchard said, "Our state bodies will cooperate with the Joint Commission on Accreditation of Hospitals in developing proper standards of inspection for the hospitals in our state." Philip A. Austin, head of the hospital and nursing home section, State Department of Health, Seattle, pointed out that the state authority was not going to rush into a poorly thought out set of regulations but would take plenty of time to get ideas from all interested groups and individuals before finally issuing standards and regulations for licenses.

The concluding session of the first day, devoted to care of the elderly, the chronic and the convalescent in the general hospital, was highlighted by a thorough discussion of the finances of this type of care. It was pointed out repeatedly that voluntary hospitals could not be expected to provide facilities for this type of patient unless they were certain that they would be



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paid full cost from some source, or sources, for this work.

The business meeting was enlivened by an argument on whether or not the Washington State Hospital Association should continue statewide negotiations with the Washington Nurses Association. After much discussion pro and con, the group unanimously approved the continuation of the negotiations.

It was agreed that the Washington State Hospital Association would recommend a $15 a month increase for registered nurses. This $15 increase would be based on the minimum base rate, which is now $245 throughout the state except in Seattle, where the base rate is $255 a month. It was voted that this increase be recommended to take effect not later than Dec. 1, 1955.

Another point which was heatedly debated was the failure of the state and local units of government to pay voluntary hospitals on the full governmental reimbursable cost formula, including depreciation on buildings, equipment and fixtures, for the care of indigent patients. At the present time, the payments received from welfare departments in the state equal about 74 per cent of cost and as a result hospitals are losing on the average $6 per day for indigent care. Hospital administrators were urged to enlist all hospital trustees and members of women's auxiliaries in the state in an effort to solve this problem.

Paul S. Bliss, administrator of the Vancouver Memorial Hospital, Vancouver, succeeded Max L. Hunt, administrator of the Yakima Valley Memorial Hospital, Yakima, as president for the succeeding year. Other officers were elected as follows: president-elect, Sister Agnes of the Sacred Heart, administrator, Providence Hospital, Seattle; first vice president, Charlotte Dowler, administrator, Shelton General Hospital, Shelton; second vice president, Chester Finkbeiner, administrator, Central Washington Deaconess Hospital, Wenatchee; third vice president, Lillian McDonald, administrator, Memorial Hospital, Sedro Woolley; treasurer, Martin N. Olsen, business manager, Swedish Hospital, Seattle. Trustees: Lawrence G. Trousdale, administrator, St. Luke's Hospital, Spokane, and Raymond F. Farwell, administrator, Swedish Hospital, Seattle, three years; Sister Amedee Marie, administrator, St. Ignatius Hospital, Colfax, two years; Alexander Babbit, administrator, Tacoma General Hospital, Tacoma, one year.

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Oregon Hospital Association Meeting

(*Continued From Page* 154)

Dr. Harold M. Erickson, Oregon's state health officer, urged hospital administrators to work with their medical staffs, employes, trustees and auxiliary and volunteer groups in the development of a disaster check list plan to clarify their thinking in the development of a workable disaster plan. Maj. John Hargreaves, medical corps, U.S. Air Force (ret.), and medical representative of the Oregon State Civil Defense Agency, urged that hospital administrators be appointed as members of local and state civil defense councils.

The afternoon session of the first day of the meetings was devoted to a discussion of the responsibilities of administrators, trustees, citizens, communities and staff to their hospitals. Dr. Jack Masur, assistant surgeon general of the U.S. Public Health Service and a trustee of the American Hospital Association, in discussing the administrator's responsibility under the title "Creative Hospital Administration," said, "There are some dreary days, especially Mondays, when a hospital administrator must feel that his lot is not a happy one. The board of trustees is apt to expect us to be clairvoyant and a financial Houdini. The medical staff claims we are happiest when making life miserable for them. But department heads tend to look at us as though we were a human petrification with a heart of feldspar, with a penchant for saying "No" to everything, especially if it involves spending a nickel. The patient's relatives are likely to stare at us for a close inspection of the hand designed like a surgical instrument that reaches deeper into their pocketbooks than anybody else with whom they trade.

"Yet," said Dr. Masur, "with all of the headaches and heartaches that hound a hospital administrator, there are compensations."

Walter W. R. May, editor of the *Oregon Voter* and member of the governor's advisory committee for hospital construction, discussed the community's responsibility to its hospital. Mr. May pointed out: "You administrators and trustees must be certain that the people in your community do understand what their responsibility is so that they can assume it." Dr. Howard P. Lewis, professor of medicine, University of Oregon Medical School, in discussing the staff doctor's responsibility, said that "doctors must give up the widely held idea that hospitals exist for their benefit."

In discussing maternity standards for hospitals at Tuesday morning's session, Dr. Robert Heilman of the hospital licensing section, Oregon State Board of Health, said that whenever a hospital has two or more cases of infant diarrhea this should be considered as an epidemic and reported at once to the health department.

At the business session closing this 22d annual meeting, the following officers were elected: president-elect, Virginia Welch, R.N., administrator, Good Samaritan Hospital, Corvallis; vice president, Sister M. Natalie, Mercy Hospital, Roseburg, and treasurer, Ross Godard, Physicians and Surgeons Hospital, Portland. Werner W. Hendrickson, administrator, Holladay Park Hospital, Portland, succeeded Irwin F. Wedel, administrator of Salem Memorial Hospital, Salem, as president for the coming year. Mr. Wedel and Mr. Hendrickson were named delegate and alternate to the A.H.A. house of delegates.



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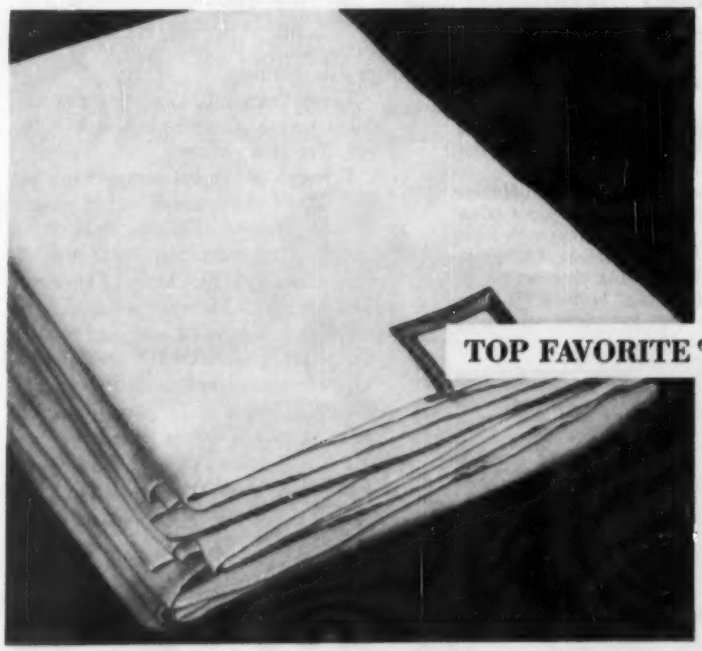
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ABOUT PEOPLE

(*Continued From Page 80*)

Sister Timothy Marie Flaherty, O.S.F., has recently been appointed assistant administrator of Queen of Angels Hospital in Los Angeles. Sister Timothy is a graduate of the St. Louis University course in hospital administration. She served her residency at St. Vincent's Hospital in New York.

Sister M. Estelle of St. Michael's Hospital, Toronto, Ont., is the new superintendent of St. Joseph's Hospital, Toronto. She succeeds **Sister M. Louise,** who has been transferred to St. Joseph's General Hospital, Comox, B.C.

Dr. Roy C. Heflebower, assistant administrator of the M.D. Anderson Hospital for Cancer Research, Houston, Tex., since 1947, has retired. Dr. Heflebower will continue to serve the hospital as special consultant.

Kay Nixon has been named assistant administrator at the Jane G. Phillips Memorial Hospital, Bartlesville, Okla.

Harold O'Neal, business manager at Huntsville Hospital, Huntsville, Ala., has been appointed administrative assistant at Hazard Memorial Hospital, Hazard, Ky.



J. H. Daniels Jr.

John H. Daniels Jr. has been appointed assistant administrator at North Shore Hospital, Manhassett, N.Y. For the last three years, Mr. Daniels has been attached to the U.S. Air Force as a lieutenant in the medical service corps. He is a graduate of the University of Minnesota's course in hospital administration, and served his residency at the Lewistown Hospital, Lewistown, Pa. He succeeds **Donald A. Kincade,** who has accepted the position of administrator of the Burlington Memorial Hospital, Burlington, Wis.

Sister Felicitas is the new superintendent at St. Joseph's Hospital, Port Arthur, Ont. Sister Felicitas was formerly administrator at Sudbury General Hospital of the Immaculate Heart of Mary, Sudbury, Ont. She is succeeded there by **Sister Mary Patricia.**

C. E. Warren, former laboratory and x-ray technician at Athens-Limestone Hospital, Athens, Ala., has been named administrator of the newly opened Arab Hospital at Arab, Ala. He succeeds **Cecil R. Hyatt,** who died in August.

W. N. Wiggs, administrator of Tillman County Memorial Hospital, Frederick, Okla., has resigned to enter private business.

Leona Penny, R.N., administrator of Montgomery County Hospital, Conroe, Tex., has resigned.

I. Joseph Shyne has accepted the position of administrator of Calumet County Hospital, Chilton, Wis. Prior to his appointment, Mr. Shyne was administrator of St. Mary's Hospital, Madison, Wis. He was graduated from the course in hospital administration at St. Louis University in 1952, served his administrative residency at the Jewish Hospital of St. Louis, later becoming administrative assistant there. He is a member of the American College of Hospital Administrators.



John C. Dumas

John C. Dumas has been appointed assistant professor of hospital administration in the graduate school of public health, University of Pittsburgh, and administrator of Falk Clinic, the outpatient

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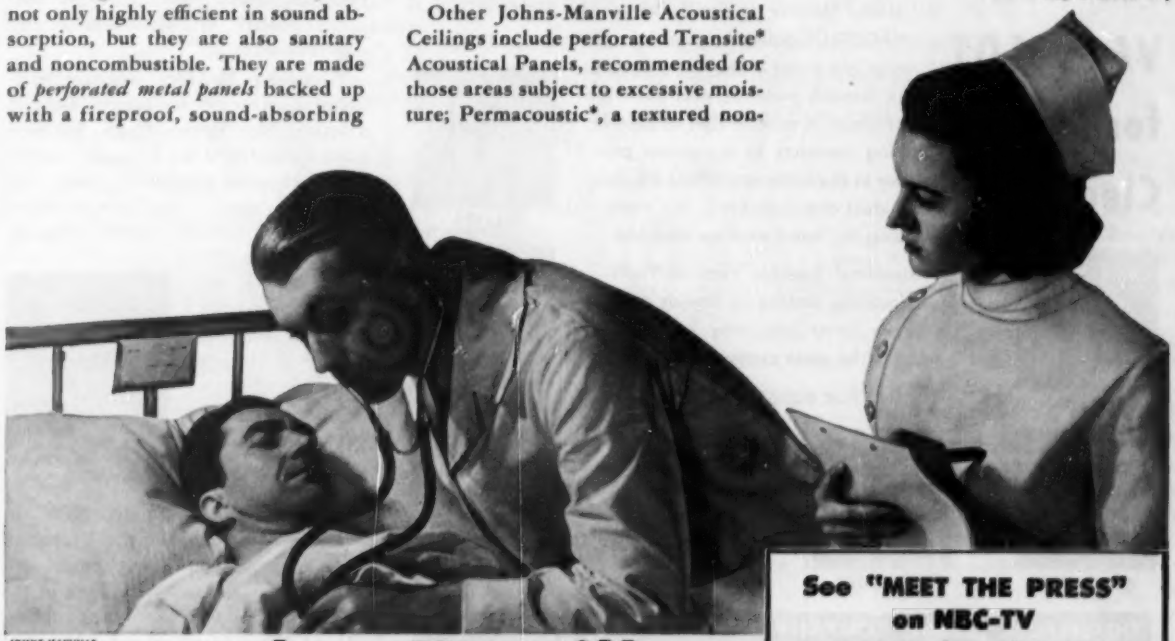
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unit of the University Medical Center. Mr. Dumas is a graduate of the University of Minnesota and served at the Abbott Hospital, Minneapolis, prior to his appointment.

Sister M. Germaine is the new administrator of St. Joseph's Riverside Hospital, Warren, Ohio. Sister Germaine was formerly administrator of St. Joseph's Hospital, Lorain, Ohio. She succeeds **Sister M. Baptista,** who is now assistant administrator at St. Elizabeth's Hospital in Youngstown, Ohio.

Dr. G. Lee Sandritter, superintendent of the Hastings State Mental Hospital, Ingleside, Neb., has been appointed superintendent of the Eastern State Hospital, Medical Lake, Wash. Dr. Sandritter also held the position of director of the Nebraska State Board of Control's central mental hygiene clinic in Hastings. He succeeds **Dr. M. M. Campbell,** acting superintendent at Eastern State Hospital.

Wilbur C. McLin has been named administrator of the new Community Hospital, now under construction in Indianapolis. Mr. McLin, whose appointment is effective January 1, is now administrator of the Mound Park Hospital, St. Petersburg, Fla. He was formerly an assistant superintendent of Methodist Hospital, Indianapolis.

Herman Seafeld, former administrator of Noxobee General Hospital, Macon, Miss., has been appointed business manager of Oates Clinic, Laurel, Miss. Mr. Seafeld is a recent graduate of Northwestern University's course in hospital administration.


J. J. Potorski

Joseph J. Potorski, assistant director at Ellis Hospital, Schenectady, N.Y., will become director of the North Adams Hospital, North Adams, Mass. Mr. Potorski is a graduate of the course in hospital administration at Columbia University. He succeeds **Dr. Robert J. Carpenter,** who died recently.

James McNee, superintendent of St. Luke's Hospital, Duluth, Minn., has retired. He is succeeded by **Richard K. Fox,** assistant superintendent.

Harold E. Wetzel, administrator of Fort Pierce Memorial Hospital, Fort Pierce, Fla., has been appointed administrator of the Anniston Memorial Hospital, Anniston, Ala.

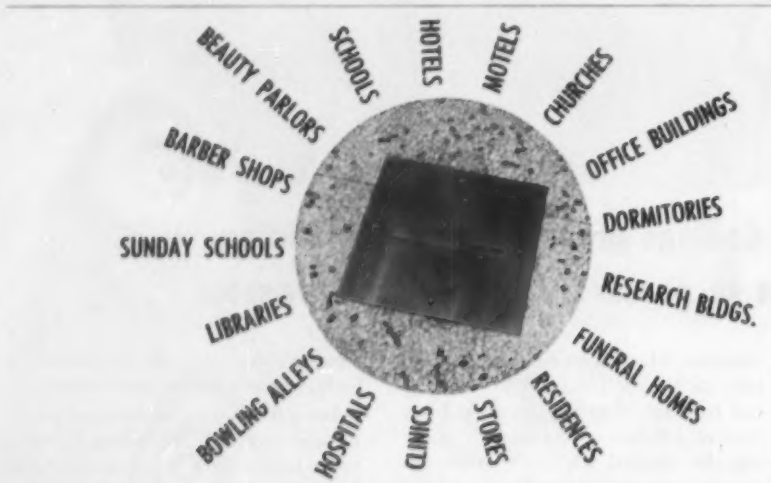
Mrs. Alfred W. Robbs, assistant director of nurses at Park Avenue Hospital in Rochester, N.Y., has been named administrator of Seneca Falls Hospital, Seneca Falls, N.Y. She succeeds **Mabel W. Gilmore,** acting superintendent.

Alexander McAliley, assistant managing director, New Britain General Hospital, New Britain, Conn., has been named director of the Franklin County Public Hospital, Greenfield, Mass. Mr. McAliley served his administrative residency at Lowell General Hospital, Lowell, Mass.


Marshall G. Ause

Marshall G. Ause, formerly assistant administrator of St. Luke's Hospitals, Milwaukee, has accepted the position of administrator of the Norwegian Lutheran Hospital, Brooklyn, N.Y. Mr. Ause is a graduate of the University of Minnesota course in hospital administration. He was an officer in the medical administrative corps during World War II and served for several years as medical administrative officer in several Veterans Administration hospitals.

(*Continued on Page* 192)



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Sister Lavina, administrator of All Souls Hospital, Morristown, N.J., for the last nine years, has been transferred to the administrative staff of St. Joseph's Hospital, Paterson, N.J. **Sister Mary Eleanor,** assistant administrator of St. Joseph's Hospital, has succeeded Sister Lavina as administrator of All Souls Hospital.

Donald M. Shute, administrative officer of the Veterans Administration department of insurance in Washington, D.C., has been appointed manager of the V.A. Center in Reno, Nev., succeeding **Edward F. Reed,** who is retiring. Mr. Shute will assume charge of the Reno office December 1.

Department Heads


Earl Schiefelbein

Earl Schiefelbein has become personnel director at Milwaukee Hospital, Milwaukee. Mr. Schiefelbein formerly held a similar position with Libby, McNeil and Libby at Janesville, Wis. He has a degree in business administration from Milton College, Milton, Wis., and has done postgraduate work in labor relations at the University of Wisconsin, Madison.

Max Q. Elder, former director of news service at the University of Pittsburgh, has been appointed director of public relations and educational services at Miami Valley Hospital, Dayton, Ohio. Mr. Elder handled much of the university's public relations of the Salk polio vaccine development. He also edited a "Survey of Alaska's Health," an extensive report compiled for the United States Department of the Interior and the Department of Health, Education and Welfare.


Philomena H. Hansen

Philomena H. Hansen, former administrative and therapeutic dietitian at Lenox Hill Hospital, New York City, has been appointed chief dietitian of the Wyoming County Community Hospital, Warsaw, N.Y. Mrs. Hansen is a member of the American Dietetic Association. She succeeds **Audrey Heary,** who is now teaching nutrition and diet therapy in the school of nursing at Rochester General Hospital, Rochester, N.Y.

Edward M. Turner has been named as comptroller of Macon Hospital, Macon, Ga., effective December 1. Mr. Turner has been with the department of public health in Atlanta as hospital accountant consultant. He received his bachelor of business administration degree with a major in public accounting from the Atlanta division of the University of Georgia.


Mary S. Price

Mary Sanders Price has been appointed director of the Johns Hopkins Hospital School of Nursing and Nursing Service, Baltimore. Mrs. Price, who is a graduate of Johns Hopkins nursing school, has served as general staff nurse, head nurse, instructor in nursing arts and assistant superintendent there. She held the rank of lieutenant colonel in the U.S. Army and served overseas from 1942 to 1946 as chief nurse with the 118th General Hospital. Following her military service, Mrs. Price held the position of associate professor at the University of Pittsburgh School of Nursing until her resignation in 1952.

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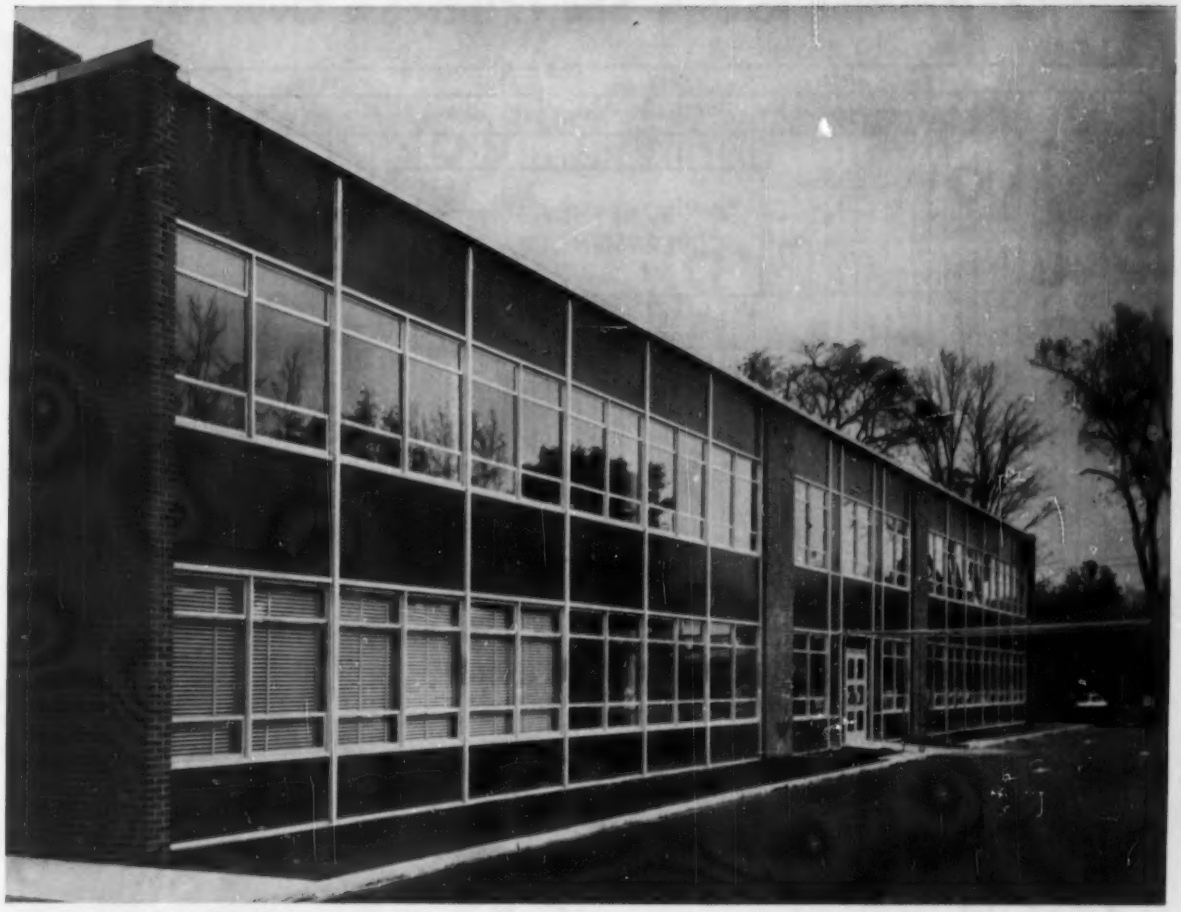
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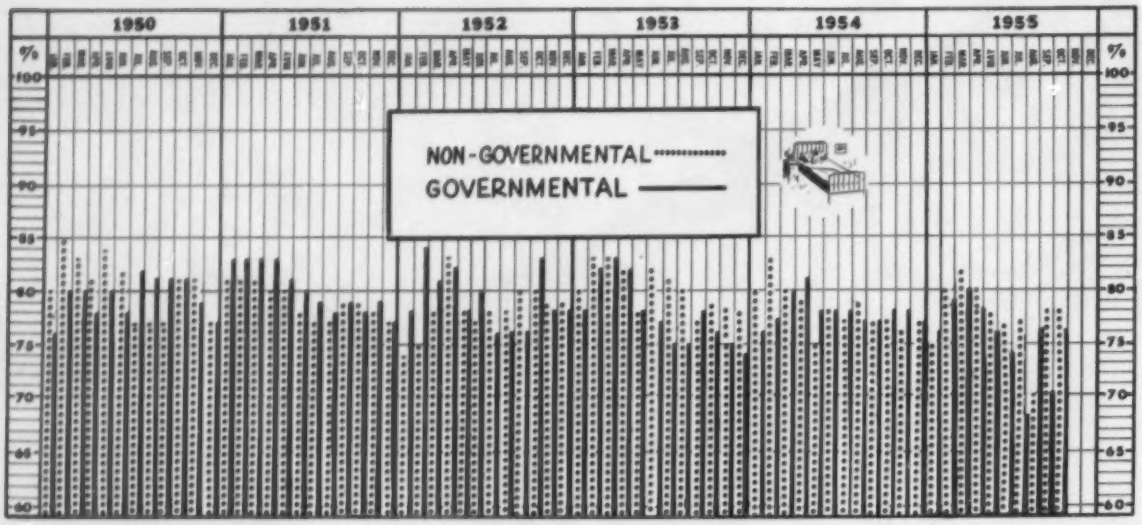
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Government hospitals reporting to the Occupancy Chart for the month of October show occupancy at 75.9 per cent of capacity, compared to 77.6 for October 1954. Voluntary hospitals reported 77.6 per cent for this October, compared to 77.5 per cent a year ago. From October 3 through November 14, construction totaled $68,214,050, bringing the year's total to date to $637,453,149. During the same period in 1954, construction amounted to $57,152,000 and brought 1954's building total to $590,238,638. Ninety-three projects were reported during the current period. Of these, 31 are hospitals, 55 are additions to hospitals, and four are alteration projects.

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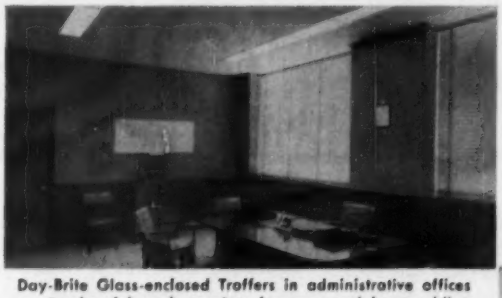
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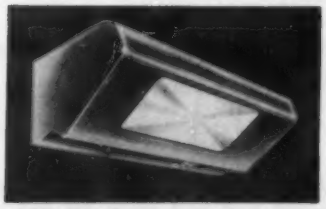
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ADMINISTRATOR—Assistant; 28; MS, Hospital Administration; 3 years, hospital and clinic experience including 2 years, hospital administrative residency and 2 years, administrator, 40-bed general hospital; seeks assistantship, large hospital.

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(Continued on page 198)

INTERSTATE—*Continued*

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POSITIONS OPEN

ASSISTANT DIRECTOR, NURSING SERVICE—Responsible for nursing service in 400-bed non-profit hospital which includes 115-bed pediatric unit; friendly city 225,000; prefer candidate with successful experience and preparation in nursing service administration; 40-hour week; salary open; position available January 1, 1956. Apply Director of Nursing Service, Iowa Methodist Hospital, Des Moines, Iowa.

ASSISTANT MEDICAL DIRECTOR—100-bed tuberculosis hospital, North American graduate, salary $8500, complete maintenance. Apply Medical Director and Superintendent, District Five Tuberculosis Hospital, London, Kentucky, or State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

DIETITIAN—For therapeutic and administrative duties in suburban hospital 16 miles west of Chicago's loop; desirable personnel policies and starting salary. Please write F. L. Unzicker, Administrator, Memorial Hospital, Elmhurst, Illinois.

DIETITIAN—Registered; full charge of dietary in busy, 64-bed, fully approved hospital; salary open. Apply Marion Memorial Hospital, Marion, Illinois.

DIETITIAN—For 60-bed general hospital; to be in full charge of kitchen and food service; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write Ralph W. Tarr, Administrator, Municipal Hospital, Grand Haven, Michigan.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Teaching; experienced, member of A.D.A. for school of nursing; good personnel policies. Write to Mrs. Aileen L. Carroll, Director of Nursing, The Buffalo General Hospital, Buffalo, New York.

DIETITIAN—Full charge ADA for 135-bed hospital fully approved. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Registered; 175-bed general hospital; salary open; for further information Apply, Mother Anne Gertrude, Administrator, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Staff; 140-bed general hospital located in suburban Philadelphia. Apply Mrs. Redman, Chief Dietitian, Delaware County Hospital, Drexel Hill, Pennsylvania.

DIETITIAN—Assistant to chief; 160-bed general hospital; college town of 25,000, 20 miles west of Milwaukee; modern dietary department completely remodeled in 1955. Write Robert M. Jones, Administrator, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF NURSES—205-bed, fully approved general hospital; applicant must have had at least five years supervisory experience with a B.A. Degree; 40-hour week; liberal vacation, sick leave, and other allowances; salary open, commensurate to professional background, Apply Superintendent, City Hospital, Lockport, New York.

DIRECTOR OF NURSING SERVICE—Top opportunity progressive 300-bed general hospital, planning new 450-bed facility; Degree, administrative line experience and high supervisory ability necessary; salary commensurate with capabilities; fine potential; position available now. Contact Edgar O. Mansfield, Superintendent, White Cross Hospital, Columbus 8, Ohio.

INSTRUCTOR—Nursing arts; salary $400.00 monthly; for complete information write Tulare-King Counties Hospital, Springville, California.

INSTRUCTORS—Clinical; two; in medical and maternity nursing; liberal personnel policies; good educational opportunities; salary open. For further information contact Director of Nursing, Presbyterian Hospital, Chicago 12, Illinois.

INSTRUCTOR—Nursing; for 184-bed general hospital; degree and experience necessary; salary commensurate with preparation; liberal personnel policies, 5-day, 40-hour week, 8 paid holidays, vacation and sick leave, group insurance and social security; salary increment of $5 twice a year. Apply Director of Nurses, William McKinley Memorial Hospital, Trenton, New Jersey.

INSTRUCTORS—Clinical; for obstetric, pediatric and medical nursing. For further information write to Director, Mercy School of Nursing, Hamilton, Ohio.

INSTRUCTOR—Clinical; surgical nursing; fully accredited school of nursing with student body of 175; position vacant January 1, 1956; applicants will be accepted immediately. Write to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

LIBRARIAN—Registered medical record; 133-bed hospital with expansion program of 40-beds; resort community 19,000; many outdoor sports available; climate ideal for hayfever victims; salary commensurate with experience, qualifications, and responsibility. Contact Mr. H. B. Lehwald, Administrator, War Memorial Hospital, Sault Ste. Marie, Michigan.

LIBRARIAN—Registered medical record; for 212-bed general teaching hospital. Contact Assistant Administrator, Mt. Sinai Hospital, Minneapolis 4, Minnesota.

LIBRARIAN—Medical records; registered or eligible for registration, to assume charge of records room; new general hospital of 150-beds and 30 bassinets; salary open; Apply giving outline of education and experience to: Executive Director, Miriam Hospital, 164 Summit Avenue, Providence 6, Rhode Island.

LIBRARIAN—Medical record; registered; to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Medical record; for 250-bed modern general hospital with extension plan. Apply Administrator, St. Mary's Hospital, Montreal, Quebec, Canada.

MEDICAL DIRECTOR—North American graduate; five years tuberculosis experience, relatively new 100-bed tuberculosis hospital; salary $10,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

MEDICAL or PSYCHIATRIC SOCIAL WORKER—Immediate opening; graduate of an accredited school of social work with related specialization for a children's hospital with a teaching program; minimum salary $4000. Write Personel Department, Children's Hospital, Columbus, Ohio.

(Continued on page 200)

PHYSICAL THERAPIST—Male or female, for small modern hospital located on shores of Lake Michigan in Michigan's northern lower peninsula; summer resort area, very desirable working conditions; please give qualifications, experience, and salary expected in first letter. Apply to Orville M. Pick, Administrator, Paul Oliver Memorial Hospital, Frankfort, Michigan.

PURCHASING AGENT—Michael Reese Hospital, a 900-bed medical center hospital, has an excellent position opened as director of the purchasing department; college degree and comprehensive purchasing experience required; specific experience in business management and industrial engineering are also desirable; Department head status and benefits; salary commensurate with experience; Write Executive Director, Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago 16, Illinois giving details of personal and professional background.

NURSING MISCELLANEOUS—Operating Room Nurses; Instructor, Assistant Supervisors, Scrub Nurses; salary and personnel policies comparable to other hospitals in this area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, New York.

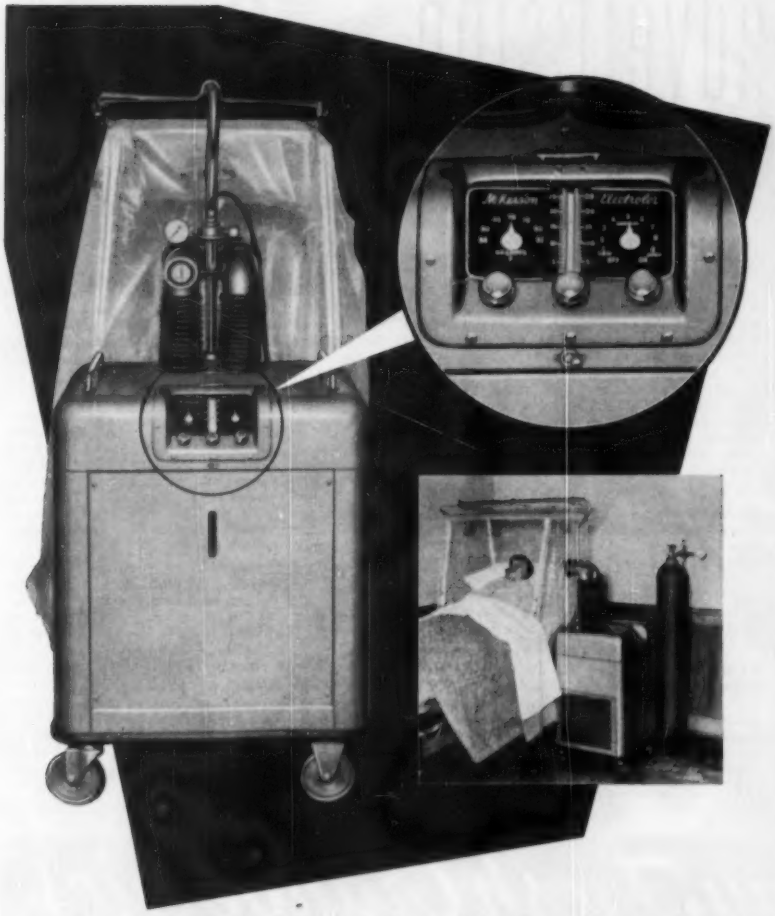
NURSES—Immediate openings for men and women nurses in a beautifully located state hospital 2 hours from New York City; active treatment program; attractive living accommodations available at moderate rate; single rooms for men and women; married couples may live in new apartment-type residence; Civil Service status after 6 months provisional appointment; gross salary $295 per month; annual increase of $15 monthly for 8 years; advancement possible; 40 hour, 5 day work week, 15 working days paid vacation each calendar year; 11 legal holidays, group insurance, Blue Cross, liberal sick allowance, retirement plan and other benefits; Connecticut registration, personal interview and physical examination are required. Apply Mrs. Rosa Lee Adams, R.N., Director of Nursing, Fairfield State Hospital, Newtown, Connecticut.

NURSES—Florida; take advantage of Florida's sunshine and pleasant living; Jacksonville's rapid growth has created a need for more hospital beds. Registered nurses are needed for surgical obstetrical and general duty; modern 375-bed general hospital on the beautiful St. John's River; basic salary $241.00 per month with increments for evening and night duty and for surgical nursing; 40 hour week. Apply Director of Nursing Services, St. Vincent's Hospital, Jacksonville, Florida.

NURSES—Consider this; a modern 150-bed hospital in a modern city of 20,000 with unexcelled community activity opportunities; starting staff nurse salary $273.00 with five merit increases; advancement opportunities; inquiries welcomed. Write for descriptive information to Director of Nurses, Midland Hospital, Midland, Michigan.

NURSES—General duty; Pacific Coast; enjoy Oregon's year-around mild climate while working at Episcopal-sponsored 450-bed Good Samaritan Hospital in Portland, Oregon; forty-hour week; beginning salary $260.00; bonus for evening and night duty; elective housing in modern attractive graduate residence; meals served at cost in cafeteria. Apply Director of Nursing.

NURSES—General duty; for 45-bed general hospital; salary $240 per month with complete maintenance; 2 weeks paid vacation after one year of employment, liberal sick leave policy with regular salary increases each six months, 5½ days per week. Contact Administrator, Howard County Hospital Foundation, Big Spring, Texas.



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POSITIONS OPEN

NURSES—General duty; 170-bed general hospital, school of nursing; 2 meals, uniforms laundered, 2 weeks annual vacation, sick leave, holidays, social security. Apply Director of Nursing Service, Maryview Hospital, Portsmouth, Virginia.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Graduate; we have positions open for graduate nurses who either have, or are willing to obtain, Colorado registry; floor duty, rotating shifts, uniform, laundry, and meals furnished, two weeks paid vacation and seven days sick leave per year; thirty-five bed hospital in a growing community. Apply MO 105, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Graduates registered; all services; for 377-bed general hospital in Milwaukee; general P.M. and night bonus; general employee benefits; 40-hour week; opportunity for continuing education at Marquette University College of Nursing; for information and personnel policies, contact, Director of Nursing, St. Joseph's Hospital, Milwaukee 10, Wisconsin.

NURSES—Graduate; for Nipigon Memorial District; 22-bed hospital; duties to commence January 1, 1956; accommodations in hospital; Address applications to Mrs. C. F. McInnis, Secretary, Nipigon Hospital Board, 309 Churchill Street, Box 457, Nipigon, Ontario.

NURSES—Head and graduate staff; for modern 300-bed expanding general hospital located in an attractive cultural city with educational advantages; all shifts, 44 hour week, excellent living quarters, periodic increases and opportunity for promotion, salary commensurate with qualifications and experience, paid vacations, sick leave, and holidays. Apply Director of Nursing Service, Memorial Hospital, 1501 Van Buren Street, Wilmington, Delaware.

NURSES—Operating room and obstetrics; California hospital on San Francisco Bay, 40 minutes from that city, 5-day week, salary $305 per month if applicant has advanced preparation or experience, $10 additional for evening and night duty, maintenance available. Apply Director of Nursing, Alameda Hospital, Alameda, Calif.

NURSES — Operating room; immediate appointments; 511-bed newly enlarged and finely equipped hospital; ten operating rooms now completed; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial and educational friendly activities; living cost reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly and considerate working associates and conditions; progressively advanced personnel policies; starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

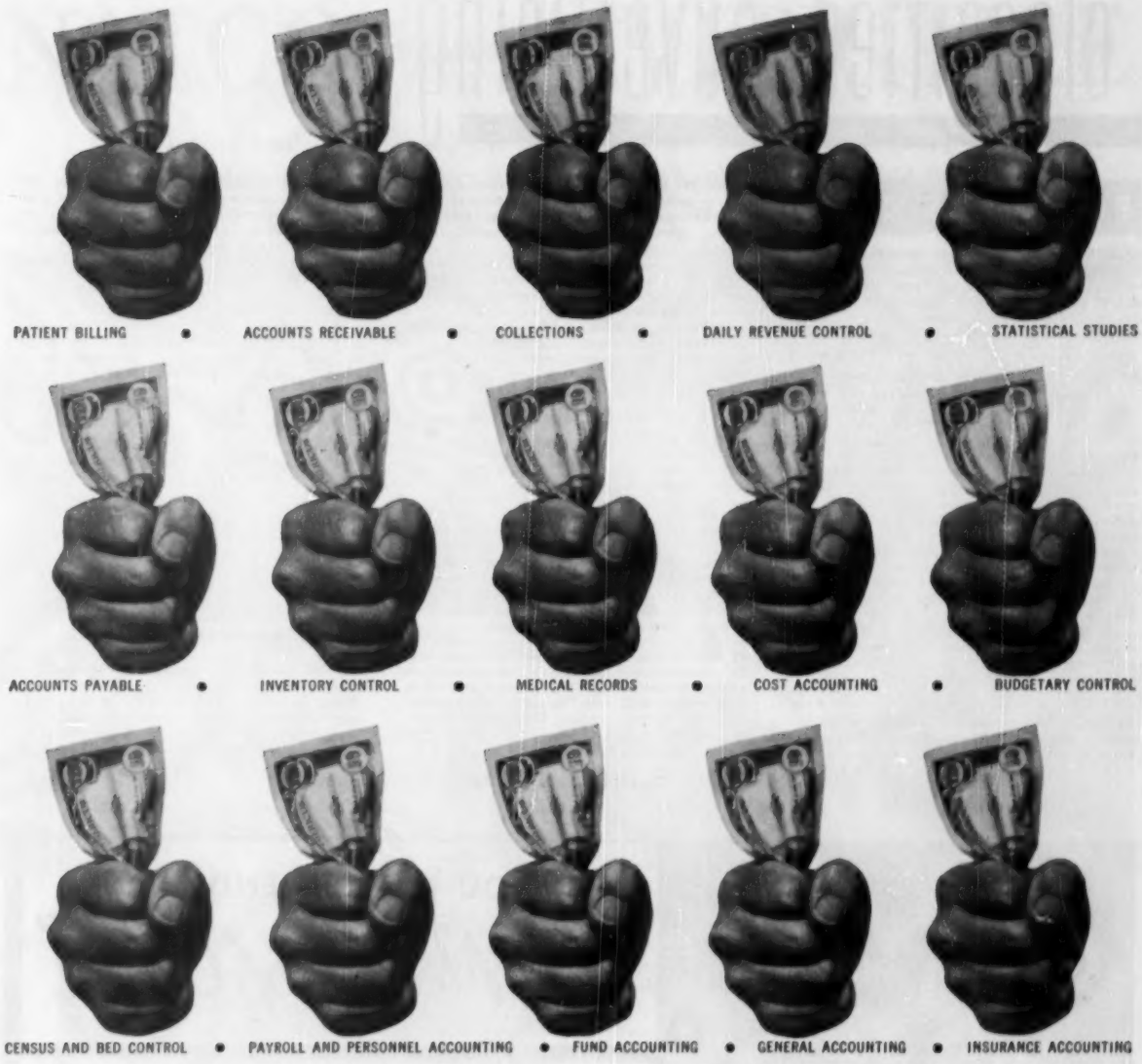
(Continued on page 202)

NURSES—Operating room staff; Pacific Coast; 450-bed, Episcopal-sponsored Good Samaritan Hospital, Portland, Oregon; new operating room and equipment; salary $270.00; forty-hour week; time off for "on call" time; all personnel policies of O.S.N.A.; elective housing available in attractive graduate residence; meals served at cost in cafeteria. Apply Director of Nursing.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE—Registered; Permanent position; live in at nursing home and health resort; beautiful mountain location. Apply to Hot Lake Sanatorium, La Grande, Oregon.





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POSITIONS OPEN

NURSES—Registered; for general duty in beautiful modern 45-bed hospital; good salary with full maintenance; 44-hour week, automatic salary increases, retirement benefits. Apply D. D. Parke, Superintendent, Belle Glade Memorial Hospital, Belle Glade, Florida.

NURSES—Registered staff; immediate appointments; 511-bed newly enlarged and finely equipped general hospital; duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial, and educational friendly activities; living costs reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly, cooperate work relations and conditions; progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES—Registered; for operating room and general floor duty. Apply, Wooster Community Hospital, Wooster, Ohio.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES—Staff; 930-bed general hospital; orientation and in-service training program; liberal personnel policies including 3 to 4 week annual vacation, paid sick leave retirement and hospitalization program, excellent opportunity for advancement. Apply Director Nursing Service, Jackson Memorial Hospital, Miami 36, Florida.

PHYSICAL THERAPIST—Woman; experienced in rehabilitation work; registered; good recommendations; five day week, 200-bed general hospital. Write P. O. Box 840, Battle Creek, Michigan.

RADIOLOGIST—Full-time associate; certified; 436-bed general hospital; very active department and fully equipped for x-ray work; opportunity for qualified radiologist, excellent remuneration; state training, experience, availability, marital status, etc. Apply Director, The Royal Columbian Hospital, New Westminster, British Columbia, Canada.

SUPERVISOR—Obstetrics; post graduate work in obstetrics and supervisory experience required; immediate opening; modern and up-to-date department; social security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

(Continued on page 204)

SUPERVISOR—Administrative obstetrics; 36-bed unit, supervisor of nursery, delivery post-partum; salary $4200, housing available, one month vacation; Blue Cross and Blue Shield group insurance, pension, 40-hour week, 270-bed teaching hospital, school of nursing, Northwestern University campus. Apply Passavant Hospital, 303 East Superior Street, Chicago 11, Illinois.

SUPERVISOR—Operating room; 65-bed hospital expanding to 100-beds; post-graduate in surgery required, 5 day week, salary open depending upon education and experience. Please apply to Director of Nursing, City Hospital, Bellaire, Ohio.

TECHNICIAN—Chief Laboratory; must be registered with ASCP; salary open. Write to Personnel Director, Methodist Hospital, Gary, Indiana.

TECHNICIAN—Combination X-ray and laboratory by November 1; salary $350.00 with assured increments and liberal personnel policies; 54-bed hospital in community of 6,500. Apply Administrator, Washington County Hospital, Washington, Iowa.

TECHNICIAN—Laboratory; for general hospital work in small institution; knowledge of X-ray technique preferable but not required; ideal location for ski enthusiast. Apply Administrator, The Memorial Hospital, North Conway, New Hampshire.



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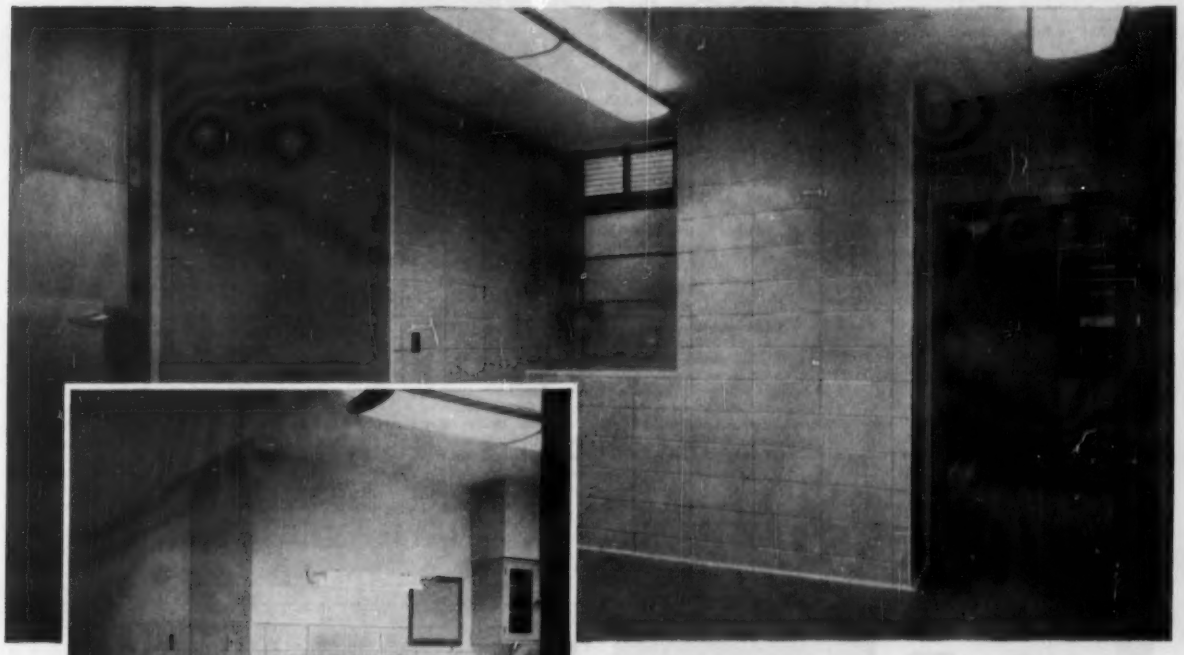
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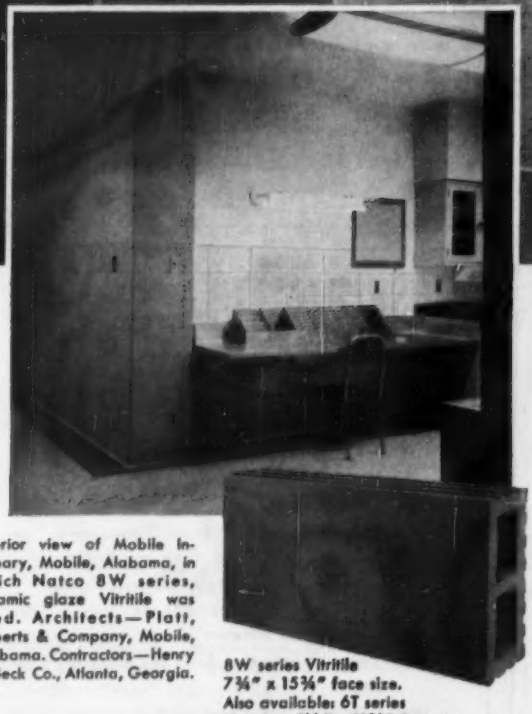
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Interior view of Mobile Infirmary, Mobile, Alabama, in which Natco 8W series, ceramic glaze Vitritile was used. Architects—Platt, Roberts & Company, Mobile, Alabama. Contractors—Henry C. Beck Co., Atlanta, Georgia.

8W series Vitritile 7¾" x 15¾" face size. Also available: 6T series Vitritile—5⅛" x 11¾" face size, and 4D series—5⅛" x 7¾" face size.

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If there is a new hospital building or an addition in the planning stage, it will pay you to investigate this proved material. We will be glad to furnish a list of Natco ceramic glaze Vitritile hospital installations on request. Write for Vitritile Bulletins 8W-455, 6T-1155, 4D-254.

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POSITIONS OPEN

TECHNICIANS—Laboratory; two, including the position as head technician, for a 245-bed general hospital. For details contact Charles Chesner, M.D., St. Joseph Hospital, Lorain, Ohio.



ADMINISTRATORS—(b) General hospital, fairly large size; construction starting early '56; large city; midwest. (c) Medical or non-medical; important general hospital, large size, affiliated university medical school; large city; east. (d) General Hospital, fairly large size operated under American auspices; South America; knowledge of Spanish advantageous. (e) Medical; prefer with experience in hospital administration; medical school affiliated hospital, 600-beds; large city. (f) 500-bed hospital primarily for treatment of tuberculosis and chest diseases; requires trained hospital administrator able reorganize business administration department; attractive offer; west coast. (g) Non-medical; several units; 300-beds; California.

WOODWARD—*Continued*

ADMINISTRATORS—Women: (a) R.N.; also serve as director of nurses; prefer with knowledge Spanish, small general hospital under American, British, Canadian auspices; salary and full maintenance; transportation paid; tropic location. (b) R.N. or non-medical; voluntary general hospital 75-beds; $6000; residential town near Washington, D. C. (c) R. N. or non-medical; 35-bed general hospital and affiliated clinic group; large university medical center; midwest. (d) R.N.; female; 100-bed general hospital affiliated very large clinic group; Pacific northwest. (e) R.N. with surgery experience new general hospital 30-beds; lovely small town; Iowa.

ADMINISTRATIVE EXECUTIVE POSTS—(n) Accountant; qualified to assume duties of business manager; voluntary general hospital small size; Rocky Mountain area. (o) Business manager to work with architect and building committee; new hospital project; College town 20,000; east. (q) Clinic manager; group established '35; staffed by 9 men; town 25000; excellent climate; southwest. (s) Comptroller; important teaching hospital 650-beds; requires experience in supervisory capacity in hospital accounting field; east. (t) Personnel Director; prefer with M.S. in personnel; general hospital 400-beds; will report direct to administrator; about $6600; large city, university medical center; midwest. (u) Purchasing Director; 800-bed teaching hospital; requires college degree, experienced in purchasing, business management, and industrial engineering background; midwest.

WOODWARD—*Continued*

ANESTHETISTS—(a) 120-bed general hospital; addition including air-conditioned surgical suite just completed; active surgical service; $500, full maintenance; lovely town 20,000; midwest. (b) General hospital 100-beds; $6000; Alaska. (c) 300-bed general hospital, medical school affiliated; $500; college community 50,000; midwest.

DIETITIANS—(a) Chief; administrative and teaching duties; 200-bed general hospital; new building to be constructed; to $5400; lovely southern community. (b) Large state mental hospital; excellent departmental facilities; to $5200; small town near city 30,000; northwest. (c) Head department; general hospital 75-beds; small community Carolinas.

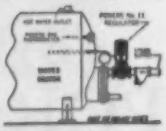
DIRECTOR OF NURSES—(a) Nursing service only; service and education under directors of equal rank, responsible only to administrator; large hospital affiliated important medical school; excellent salary and benefits; large city; south central. (b) Nursing service; building program will increase to 400-beds; one of finest hospitals and locations in Pacific Northwest. (c) Nursing service and education; 500-bed general hospital; accredited school; start $7500, increase to $9000 by 4th year; Midwest.

(Continued on page 206)



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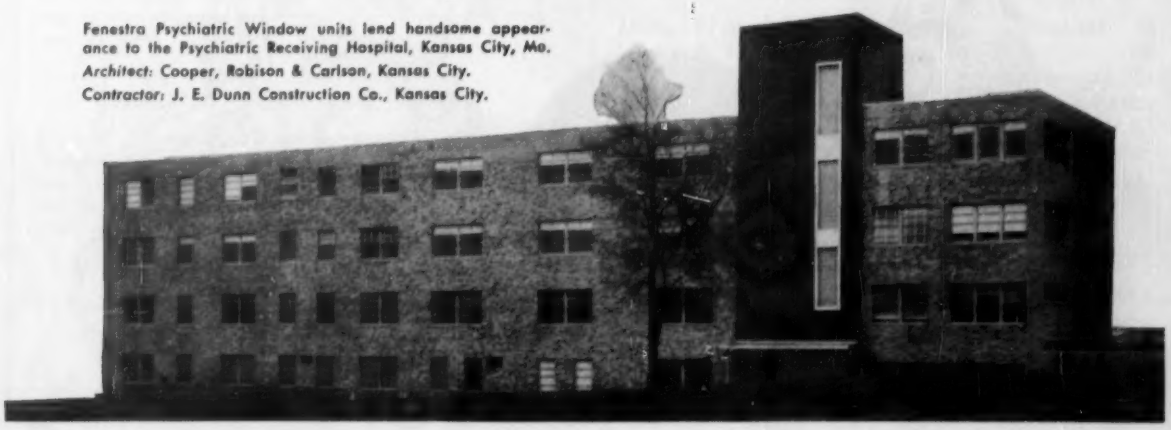
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Contractor: J. E. Dunn Construction Co., Kansas City.



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POSITIONS OPEN

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) Voluntary general hospital 200-beds; excellent facilities; town 25,000; east. (b) Supervise staff of 75; 400 bed university hospital; California. (c) Full responsibility, hospital, 4 nurses' homes, educational building; staff of nearly 50; 200-bed teaching hospital; excellent eastern location.

FACULTY POSTS—(a) Educational director; full responsibility, nursing school now temporarily accredited; fully aproved 300-bed general hospital; to $4800; lovely college community; midwest. (b) Educational director; 3 year program; 125 students, will increase to 150 shortly; collegiate affiliated school; 200-bed general hospital; excellent medical staff; top salary to qualified person; town 35,000; northwest. (c) Clinical instructor, medicine or surgery; voluntary hospital 150-beds; attractive midwest college town 50,000. (d) Science instructor; fully approved 250-bed general hospital; residential suburb, large university medical center; east.

SUPERVISORS—(a) Operating room; 300-bed general hospital just completed; fully air-conditioned; attractive offer; large city; southeast. (b) Pediatrics; approved 250-bed general hospital; training school; lovely town 15,000; southeast. (c) Operating room; very large university hospital; affiliated important medical school; south.

SUPERVISORS—(a) Obstetrics; 35-bed unit; teaching required; voluntary general hospital 300-beds; $4200; resort town near New York City. (b) Operating room; small general hospital; JCAH approved; $4500; attractive small town; southwest. (c) Operating room; active surgical service; 6 room suite; staff of 15 in addition to students; 300-bed general hospital; excellent personnel policies; town 50,000; New England. (d) Operating room; prefer post graduate training; JCAH voluntary general hospital 100-beds; $4800; attractive town 15,000; Pacific Northwest. (e) Obstetrics; 65-bed unit; 2 floors and delivery room suite; some teaching; college affiliated school; large general hospital; east.

The Medical Bureau

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ADMINISTRATORS—(a) Medical director to take complete charge of medical services, clinics and laboratories in dynamic hospital setting; large hospital specializing in psychiatry; east. (b) Medical director; duties consist of directing educational program, coordinating all medical aspects; voluntary general hospital, 500-beds; east. (c) General 250-bed hospital affiliated university operated under American auspices, foreign city; duties include conducting program for hospital administrators. (d) General 125-bed hospital functioning essentially as community hospital for British and American colonies in foreign country; expansion program; $12,000; cost of living between ½ and ⅔ of United States. (e) General hospital, 60-beds; expansion program increasing to 120; resort city, Florida. (f) Assistant; large general hospital affiliated medical school; although medical preferred, non-medical eligible; opportunity succeeding director within two years. MH12-1.

ADMINISTRATORS—WOMEN—(a) Modern, small hospital; attractive city outside United States; English-speaking staff. (b) New 40-bed hospital; completion early 1956; available soon to engage staff; wealthy agricultural area; midwest. MH12-2.

ANESTHETISTS—(a) General 150-bed hospital; resort town, near two university cities; midwest; $500-$650. (b) New small hospital; salary or free lance; Texas. (c) Small general hospital; Hawaii. (d) Association, 20-man group; modern 200-bed hospital; medical anesthesiologist; top salary; college town, midwest. (e) Staff; large general hospital; greater New York area; $4800, maintenance. MH12-3.

(Continued on page 208)

Relax the best way ... pause for Coke



Time out for refreshment

DRINK Coca-Cola



UNCONDITIONALLY GUARANTEED

HOSPITAL SHEETING

by

Guaranteed by Good Housekeeping

Plymouth

RUBBERIZED heavy weight COATED SHEETING

Double coated hospital sheeting. Boilable—.016 thickness. Guaranteed to comply with all the requirements of CS TS-355la as issued by the National Bureau of Standards and Federal Specification ZZ-S311A. Resists urine, blood, alcohol, perspiration, medication, glycerine. Colors: maroon, white. 12 and 25 yd. rolls.

No. 1801 Double Coated 36" width; No. 1802, 45" width; No. 1803, 54" width.

No. 1807 Same as above except .020 thickness, 36" width.

DOUBLE TEXTURE FLANNELETTE

Waterproofed sheeting, soft and absorbent, napped on both outer surfaces. Has inner layers of natural rubber. Used in baby's crib or adult hospital bed, directly over mattress. No other pad or sheeting necessary. 12 and 25 yd. rolls.

No. 1811, 36" double texture flannel, rubberized fabric, white.

Durable Vinylite SHEETING

A lightweight, non-allergic covering. This exclusive Plymouth sheeting is long-wearing and highly resistant to moisture absorption. Saves laundering. Light but durable—it won't crack or stick—wet or dry. In 12 or 25 yd. rolls.

No. 1601 Clear .004 thickness, 36" width. No. 1602 Clear .004 thickness, 45" width. No. 1603 Clear .008 thickness, 54" width.

ALL RUBBER (Non Fabric) SHEETING

Completely waterproof, odorless, boilable. Resists perspiration, alcohol, urine, blood; stays smooth and pliable in hot and cold temperatures; won't crack or peel. Can be sterilized. 12 and 25 yd. rolls.

No. 1401 36" Unsupported gum rubber, two ply white, maroon, flesh/white, flesh/blue. .016 thickness.

ELECTRIC CONDUCTIVE SHEETING

No. 1413 Double coated fabric. Conforms to specifications of National Fire Protective Association. Color: black. .020 thickness, 36" width only.

WONTARE (WON'T TEAR) VINYLITE

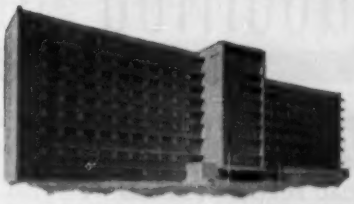
No. 1415 The most durable type of unsupported heavy weight Vinylite sheeting, embossed. Highly resistant to moisture absorption. Soft, flexible. Will not crack or stick whether wet or dry. Can be sterilized. Meets every test of Specifications 22-311A. Color: maroon. .015 thickness, 36" width. 12 and 25 yd. rolls.

PLYMOUTH RUBBER COMPANY, INC.

THE LARGEST RUBBERIZERS OF CLOTH IN THE WORLD

Canton, Massachusetts

Performance-Proved at



ST. VINCENT'S INFIRMARY

Little Rock, Arkansas





Top picture shows exterior of new St. Vincent's Infirmary in Little Rock, Ark. Directly above is a general view of the kitchen, showing two HERRICK 6-door Stainless Steel Refrigerators. At left is a close-up of Herrick Model SS60B. Architects for the new hospital were Brueggeman, Swaim & Allen, and Erhart & Eichenbaum. HERRICK units were supplied by Krebs Bros. Supply Co., Inc.

HERRICK

STAINLESS STEEL REFRIGERATORS*

Designed to give the very finest in hospital care, St. Vincent's Infirmary also provides its patients with the best in flavorful, nutritious foods. Serving the new, modern kitchen are 6 HERRICK Stainless Steel Refrigerators. These dependable HERRICKs assure the ultimate in carefree convenience, spotless sanitation and complete food conditioning. HERRICK Refrigerators will do the same for you. Write for name of your nearest HERRICK supplier.

***Also available with white enamel finish**

HERRICK REFRIGERATOR CO., WATERLOO, IOWA
DEPT. M., COMMERCIAL REFRIGERATION DIVISION

HERRICK *The Aristocrat of Refrigerators*

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIETITIANS—(a) Chief; 200-bed modern hospital; year-round resort area; $6000. (b) Chief; new 300-bed general hospital affiliated medical school; Pacific Coast. (c) Assistant; teach therapeutics; well equipped department; largest hospital in state; south; $6000. (d) Chief; new general 225-bed hospital; completion March; university city, south. (e) Nutritionist; large general hospital; college town, California. MH12-4.

DIRECTORS OF NURSING—(a) Dual responsibility, school and service; 500-bed general hospital; college town, California; $7500. (b) General 400-bed hospital currently under construction; completion late 1956; preferably one available early part of 1956 in order to organize departments; university city, south. (c) Director, school; general 500-bed hospital; 90 students; university city, midwest; $6000-$7200. (d) Nursing service; $3,000,000 building program; large teaching hospital; west coast. (e) Associate director; 300-bed general hospital operated under American auspices, foreign country; $7500, maintenance. MH12-5.

EXECUTIVE HOUSEKEEPER—General 400-bed hospital, unit of university medical center; expansion to 800; university city; $4200-$4600, attractive apartment. MH12-6.

EXECUTIVE PERSONNEL—(a) Comptroller; 900-bed general hospital; supervisory experience required; east. (b) Directors of personnel and purchasing; 400-bed general hospital; university city, south. (c) Office manager; staff of 20; accounting background required; 400-bed general hospital; university city, midwest. (d) Food manager; university hospital, 450 beds; east; $7000. MH12-7.

FACULTY POSTS—(a) Director, vocational nursing program; collegiate affiliation; attractive location, Pacific Coast; $500-750. (b) Assistant professor, nursing arts; renowned university. (c) Assistant director, nursing research; 500-bed teaching hospital; university center, midwest. (d) Educational director, qualified organize new university program; northwest. MH12-8.

RECORD LIBRARIAN—(a) Chief; teaching hospital; $5000-$6000; greater New York area. (b) Chief; general 400-bed hospital currently under construction, completion late 1956; preferably one available early part of 1956 in order to establish department; university city, south. (c) New small general hospital; ideal coast resort city, Florida. MH12-9.

SUPERVISORS—(a) Operating room; 200-bed general hospital with expansion program to 425; busy surgery; college town, California. (b) Evening and pediatric supervisors; duties: teaching and administration; 200-bed hospital affiliated university; 70 students; near East. (c) Floor supervisor with ability to act as director of nurses, 25-bed new hospital; ideal Florida location. (d) Obstetrical, medical, surgical; 250-bed general hospital; free tuition at affiliating college, New York City area; $4500. MH12-10.

(Continued on page 210)

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR — (a) 150-bed hospital, Pennsylvania; expansion planned, 100-bed wing. (b) 80-bed hospital, mid-west. (c) 95-bed hospital, New York State. (d) New 50-bed hospital, suburb large western city. (e) 50-bed hospital, Ohio.

ADMINISTRATOR—R.N. (a) Small modern hospital, New York. (b) 35-bed hospital, west. (c) 140-bed hospital, Pennsylvania; open January.

DIRECTOR OF NURSING—(a) 400-bed Ohio hospital; $6,500 maintenance. (b) 250-bed hospital, mid-west. (c) 165-bed hospital, Ohio. (d) 100-bed south central state; modern new hospital. (e) 300-bed hospital, Pennsylvania. (f) 80-bed hospital, southwest.

TECHNICIAN—(a) X-ray; large clinic; salary open. (b) Chief laboratory technician—Ohio; $500. (c) Laboratory X-ray; to $400.

MEDICAL RECORD LIBRARIANS—(a) To $400. (b) Administrative dietitian; $500. (c) Anesthetists; $500.

EXECUTIVE HOUSEKEEPER—(a) 300-bed modern hospital, south central state. (b) 180-bed hospital, Pennsylvania. (c) 225-bed university hospital. (d) 300-bed New England hospital. (e) 325-bed hospital, Ohio.



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Why? First, cost . . . second, strength . . . third, design. Hampden's first on all three counts! Write for a sample chair, inspect it, test it, no obligation.

This is Hampden's No. 73. Steel frame, contoured plywood seat, baked-on enamel is chip resistant. Rubber feet.



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...YOU'LL WANT THIS!

SEND FOR THIS USEFUL FREE BROCHURE TODAY

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Please send Nursery Equipment Brochure.

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Blanche L. Shay, Director

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Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Purchasing agent; middle west; one of countries leading hospitals; $7500. (b) Accountant; south; 100-bed hospital; supervise personnel in business office—prepare statistical statements; $4800-$6000. (c) Public relations director; south; large hospital; require good public relations experience and sound comprehensive knowledge of human relations; $7000-$10,000. (d) Business manager; middle west; 250-bed hospital in large city. $6000. (e) Assistant administrator, southwest; accounting experience required; 135-bed hospital. (f) Clinic manager; southwest. 25 physicians in group; 50 employees. New modern building; $8000-$10,000. (g) Purchasing agent, south; 300-bed hospital in large city; $6000. (h) Business manager; middle west; 80-bed hospital in college town of about 10,000; $6000. (i) Business Manager; east; private clinic; 25 physicians; excellent opportunity; $6000-$8000. (j) Director of building services; west; will act as assistant superintendent; large hospital; some college engineering training, plus experience. $7000.

SHAY—*Continued*

MEDICAL TECHNOLOGISTS—(a) East; 500-bed hospital; laboratories all new and modern; must be A.S.C.P. to $6500. (b) Chief; California; 160-bed hospital near San Francisco; $470. (c) Chief; east; complete supervision of laboratory; 4 years experience at least; 250-bed hospital; $475. (d) Chief; middle west; supervise 2 clinical laboratories under direct supervision of certified pathologist; $500. (e) South; 125-bed hospital, 3 technologists in laboratory; $325. (f) Pacific Northwest; 100-bed general hospital, fully approved; $375. (g) Blood Bank; middle west; 100-bed hospital in small college town; can continue work toward degree if desired; $350-$400. (h) East; Blood chemistry and some bacteriology; 200-bed hospital; $300 plus maintenance.

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Southern Hospitals look to us for personnel. We have openings for Nurse Anesthetists, Laboratory Technicians, Nursing Directors, Dietitians. Let us help you locate the opportunity you are seeking.

(Continued on page 211)

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Mary A. Johnson, Ph.D., Director

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Note how drain slides line up with top of extractor and washer doors hinge on opposite sides for convenience . . . exclusive design features found only on CHICAGO Equipment.

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X-4	ARMSTRONG X-4 (Nursery Type) BABY INCUBATOR Designed for use in the nursery. Underwriters' Laboratories Approved.
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	Write for complete details on any or all of these 3 Armstrong Baby Incubators.

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QUALIFIED NURSE PERSONNEL
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Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.

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New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
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(Continued on page 212)

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

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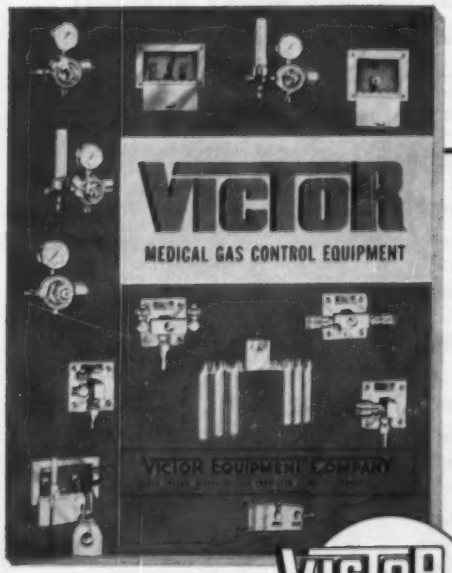
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GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

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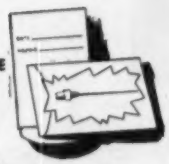




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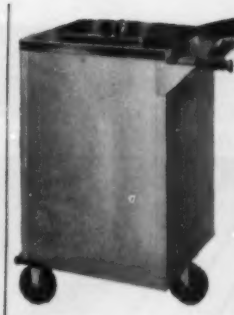
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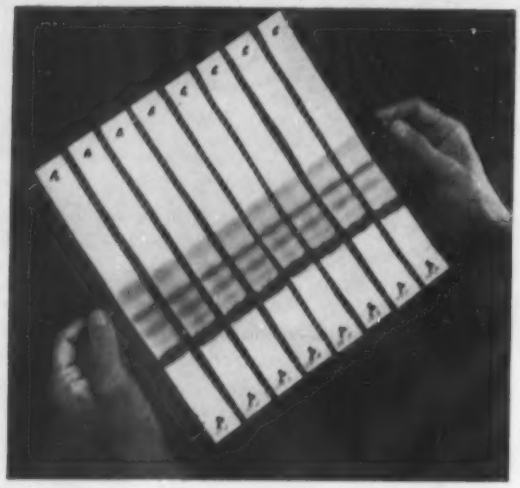


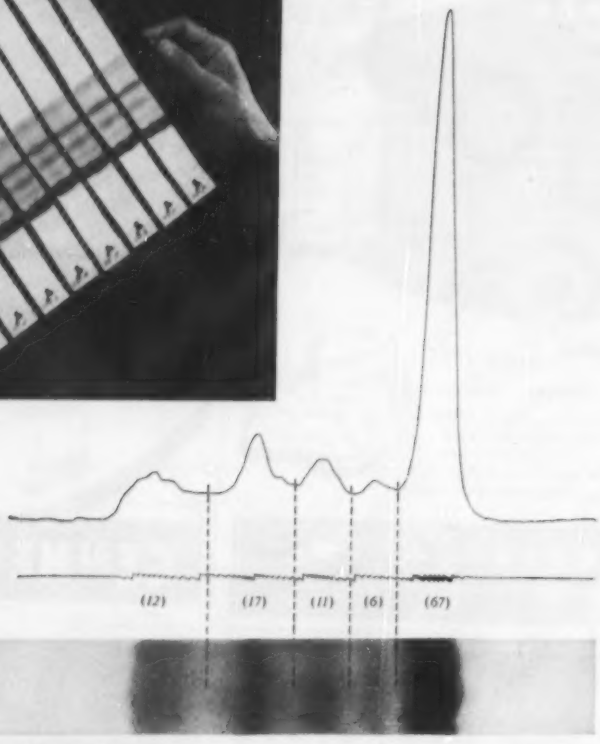
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TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 230. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Narcotic Cabinet for Safe and Simple Dispensing

Safe control and dispensing of narcotics at the nursing station is possible



in a simplified manner with the new Pentype Automatic Narcotic and Barbiturate Cabinet. The system ensures safety in dispensing narcotics and barbiturates while saving hours in counting and record keeping. The safe, locked storage cabinet for narcotic tablets and vials as well as capsules, contains 12 Pentype dispensers, 15 storage bottles and room for 20 narcotic vials. It has a special cylinder lock and an attachment to secure it in a drawer or cabinet, yet permits removal for refilling.

The Pentype automatic dispensers and counters for tablets dispense all standard size .161 inch diameter hypo tablets. They provide storage as well as automatic counting. One tablet is ejected from the barrel when the top button is depressed. Breakage of tablets is prevented as is contamination. Tablets are kept clean and ready for immediate dispensing by a touch of the button. The dispenser is made of indestructible plastic and can be labeled according to the contents. Numbers are marked on the side so that a glance indicates the number of tablets remaining in the dispenser. Tablets are handled but once with this system—when they are loaded into the dispenser. Storage bottles of narcotics and barbiturates also have an automatic counting system on the top. The contents of the cabinet are safeguarded by the safe, strong lock. **Physicians & Hospitals Supply Co., 1400 Harmon Place, Minneapolis 3, Minn.**

For more details circle #64 on mailing card

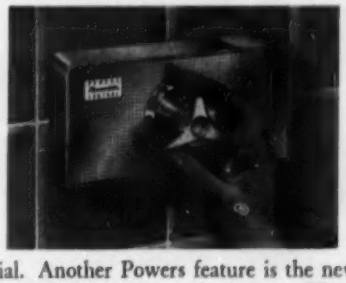
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A new eight inch V.D.R.L. and a taper top serological pipette have been added to the line of Pyrex brand laboratory glassware. The new pipettes are designed to help increase efficiency and speed in serological work. The eight inch pipette is a 5/10 ml unit with 1/100 ml graduations. It is light and short and is easy to handle, especially in guiding the tip to spot plate rings and depressions. A mouthpiece tapered to permit easy insertion and removal of a cotton filter distinguishes the taper top pipette. It is available in seven sizes with graduations of either 1/10 ml or 1/100 ml. The new pipettes will withstand repeated wet or dry sterilization and are mechanically strong with tips smoothly ground with a double bevel to resist chipping. **Corning Glass Works, Corning, N.Y.**

For more details circle #65 on mailing card

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An advanced style trend in thermostatic shower control is offered in the new Powers Type H Hydroguard. The rectangular dial in two-tone chrome finish is an interesting and attractive departure from the conventional round



dial. Another Powers feature is the new Triple Duty Strainer-Check-Stop. These fittings, located behind the Hydroguard dial, reduce installation cost and improve appearance. Only one hole for piping must be made in the tile wall.

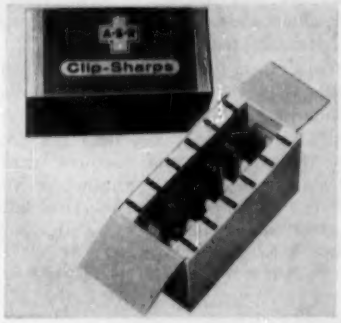
Attractive appearance and compact arrangement of the triple duty fittings make the Hydroguard particularly applicable for institutional use. In addition to the new features, it retains the traditional safety and comfort provided by Powers thermostatic control. **Powers Regulator Co., 3400 Oakton St., Skokie, Ill.**

For more details circle #66 on mailing card

(Continued on page 216)

Surgical Blades in Convenient Packing

Clip-Sharps is the name given to a new convenient, economical method for packing surgical blades. Each box contains one gross of ASR surgical blades in



units of 24 unwrapped blades per clip. This eliminates the need for handling individually wrapped blades and permits removal of the required number of blades. From one to 24 blades can be easily removed from the clip and placed on a rack arm which is then inserted in the sterilizing solution.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used with Clip-Sharps. They provide a quick, easy and low-cost method of handling a small or large number of blades without the time and cost involved in handling individually wrapped blades. Clip-Sharps are supplied six clips to the box, protected by rust inhibiting paper. **American Safety Razor Corp., 380 Madison Ave., New York 17.**

For more details circle #67 on mailing card

Universal Liquid Cleaner Is Safe on All Surfaces

A special synthetic cleaning agent is chemically "locked into" the new Wyandotte Universal Liquid Cleaner. Known as Ammosene, the cleaning agent is the result of more than two years of research and field testing. Universal Liquid Cleaner is safe on all surfaces, according to the manufacturer, and is easy on users' hands. It is designed for use on all washable surfaces for speedy cleaning at low cost. Universal Liquid Cleaner is marketed in five, 30 and 55 gallon vinyl, plastic-lined drums. The five gallon size is provided with a pouring spout. **Wyandotte Chemicals Corp., Wyandotte, Mich.**

For more details circle #68 on mailing card

WHAT'S NEW

Oven and Tableware in Surface-Stressed Glass

Duralex is the name given to a line of surface-stressed glass oven and tableware recently introduced into the American



market. Qualities of the glass line include shock resistance, immunity to oven heat up to 600 degrees F. and to the hottest cooking liquids, no discoloring, cracking or crazing, heat or cold retention, virtual unbreakability in ordinary use and absence of sharp cutting edges or splinters in case it should break.

Manufactured by Saint-Cobain of Paris, France, the line includes tumblers, cups, saucers, bowls, compotes and plates in a complete range of sizes and styles. It is solid glass, does not have any taste or odor, and does not scratch or stain. Attractive appearance is combined with long wear and service. **Intercontinental Glassware Co., Inc., 50 Church St., New York 7.**

For more details circle #69 on mailing card

Mint Fragrance in Germicide-Deodorizer

The pleasant fragrance of mint is combined with germicidal properties and refined deodorizing action in Mintol, a new multi-purpose germicide. It is designed for use wherever a germicide is needed or where offensive odors are present. It has met the new "Use Dilution Confirmatory Test" on S. Cholerasuis in accordance with the current Food and Drug Administration Testing methods, according to the manufacturer. It dilutes economically for disinfecting or deodorizing. **The C. B. Dolge Co., Westport, Conn.**

For more details circle #70 on mailing card

Giant Washing Machine for Heavy Institutional Needs

A new heavy-duty machine is available for installations where there is need for washing large numbers of dishes, pots and pans. Pieces to be washed are carried on a special flat nylon conveyor belt through three recirculating wash sprays and two fresh water rinses. The final stage uses a



chemically pure rinse to eliminate all residue. Seventy-six specially designed nozzles completely wash away every type of foreign matter in the first two stages of the cleaning job. Constant efficiency is assured through use of pressure gauges on both top and lower spray systems. **Champion Dish Washing Machine Co., 311 State St., Erie, Pa.**

For more details circle #71 on mailing card

Individual Radio Paging Developed by Motorola

A new pocket radio paging system has been developed by Motorola for paging doctors and key personnel. The "Handie-Talkie" Radio Paging System gives private, individual paging anywhere in the hospital without noise or fuss. Only the person paged is aware that a message is being transmitted. The individual radio receiver is carried by each doctor or other key person when going through the hospital. The receptionist or telephone operator merely presses the proper selector button to activate a particular receiver alerting mechanism, then speaks the message into a desk microphone. The individual to be paged receives the message on his individual receiver. No other receiver in the system hears either the alerting tone or the voice message.



The system consists of a selector console with individual buttons for key personnel, an FM transmitter that radiates alerting tones and the voice messages within a confined area, and the individual receivers. The selective calling method utilized is identical in principle to that developed by Motorola for individually alerting commercial or military aircraft in flight. The receiver itself is only slightly larger than a king size package of cigarettes. It can be clipped in a pocket or worn on a belt. Its FM reception is immune to common types of interference generated by x-ray, diathermy and other equipment in the hospital. Battery life is approximately four 40 hour weeks. Operating cost is low and convenience and time-saving are plus factors. While the volume of the paged message is adequate for the paged individual to hear, it is low enough to preserve privacy and to avoid disturbing patients or others nearby. Up to several hundred persons can be paged individually through the system by adding channel capacity as needed. **Motorola Communications & Electronics Division, 4545 W. Augusta Blvd., Chicago 51.**

For more details circle #72 on mailing card

(Continued on page 218)

Intravenous Arm Splint Is Featherweight

The new Mono-Splint is designed to simplify the intravenous administration



of fluids and blood by holding the arm outright and steady. Accidental dislodging of the needle and the danger of cutting off flow are eliminated. The featherweight arm splint is easily attached to the bed spring or operating table arm for stability. The arm is held at the wrist and above the elbow by an adjustable strap. Made of indestructible plastic which requires no padding and permits x-raying, the Mono-Splint is furnished complete with a smooth, comfortable hand grip. **Curvlite Surgical Products, Div. of Mastercraft Plastic Co., Inc., 95-01 105th St., Jamaica 35, N. Y.**

For more details circle #73 on mailing card

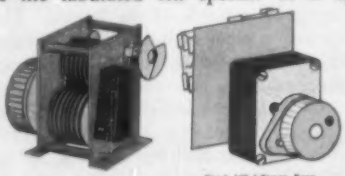
Name Plates and Signs of Plexiglas

Desk and door nameplates and special signs made of Carrol Line Plexiglas are now available. The attractive nameplates and signs are available in a variety of transparent, translucent, opaque and fluorescent colors in many different styles. **Marshall Plastics Co., 308 N. Morton, Okmulgee, Okla.**

For more details circle #74 on mailing card

Timing Instrument at Low Cost

A patented timer and programing instrument is available with ten instantly selected speeds. It is easy to operate and low in cost. The synchronous motor drives a series of gears which are continuously in mesh. The pick-up gear slides along its shaft to the desired speed. This is the only rotating shaft. The adjustable cam gives from five to 95 per cent of the time cycle on or off at each of the tabulated ten speeds. It is ap-



plicable for electrical single switching or multiple switching and for mechanical operation for instruments and apparatus drives, such as chart movers. Other models are available with 13 speeds. **Gorrell & Gorrell, Haworth, N. J.**

For more details circle #75 on mailing card



Kenrubber floors **quiet** busy feet

Here is flooring so lastingly resilient you'd think coiled steel springs were imbedded in each tile! That's how KenRubber Floors cushion every footfall, hush the din of constant traffic in rooms and corridors and help reduce fatigue for all who walk. KenRubber's pre-polished surface resists dirt and stain...crisper, clearer, tile-deep colors stay fresh, and sparkling clean with minimum maintenance effort and expense. Wherever durable long-wearing floors are needed...KenRubber offers these *extra* advantages no other floor can equal. For further information contact your Kentile, Inc. Flooring Contractor.

KENRUBBER.

TILE FLOORS

KENTILE, INC., 58 3RD AVENUE, BROOKLYN 15, N. Y.

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WHAT'S NEW

Overbed Table and Screen in Single Unit



The Centaur table is basically a double pedestal overbed table which incorporates a vinyl-coated hospital screen in the same unit. The table has a melamine plastic top with non-rusting, non-tarnishing edging and double ball-bearing swivel casters with conductive rubber wheels. It is available with one-section or three-section top, the latter equipped with a mirror and a removable utility tray.

The screen, an integral part of the unit, is opaque and shadowproof. It needs no laundering and is wiped clean with a damp cloth. It is durable and is available in a choice of pastel colors, including beige, green and blue. Dark accents and color combinations are available on request. To convert from the screen position to a simple overbed table, it is necessary only to retract the screen into its housing on a spring roller and press down on the top of the screen extension which will telescope downward exactly flush with the table top. The locking mechanism for all positions is simple and fully automatic. The Centaur table is designed to save space in the patient's room and to give trouble-free service. **The Centaur Corporation, 92-40 Queens Blvd., Forest Hills 74, N.Y.**

For more details circle #76 on mailing card

Telephone Switchboard for Private Telephones

The new Telecom Model 4A30 Dial Telephone Switchboard is designed for installations requiring 20 to 50 private telephones. Simple plug-in units provide expansion from minimum equipment to a maximum of eight links and 50 lines. The switchboard comes completely equipped and requires only the addition of telephones to be placed in operation. Top quality intercommunication service is provided by the new model. Special features such as paging, speaker phone, code call and others are available in addition to normal intercommunication service. **Telecom, Inc., 1019 Admiral Blvd., Kansas City 6, Mo.**

For more details circle #77 on mailing card

Improved Dishwasher Has Rinse Water Booster

A 180 degree final rinse water booster has been developed for installation on the Model D all-purpose small space dishwashing machine. It is available for use with gas, steam or electricity. A newly developed revolving wash and new lightweight balanced final rinse line are other improvements on the Model D. Stainless steel strainer pans, tracks, wash arms and other parts in the new model are included to withstand the stronger action of detergents now in general use. The machine operates at low water pressures. **Universal Dishwashing Machinery Co., 49 Windsor Place, Nutley, N.J.**

For more details circle #78 on mailing card

Utility Table in Stainless Steel

Accessibility to the three shelves of the new stainless steel utility table is increased through the lack of corner posts in the design. The frame of ¾ inch stainless tubing is formed into a convenient push handle. Each shelf has a guard rail. Quiet, easy mobility is assured through the large, three inch diameter wheels with replaceable cushion rubber tires. Casters have double ball bearing swivel forks. The table is 34¼ inches high, overall, and shelves are 16¼ by 20 inches with an 11 inch shelf clearance. **The Colson Corporation, Elyria, Ohio.**



For more details circle #79 on mailing card

Voltage Controller in Midget Size

The new Fisher Midget Voltage Controller occupies only 4 by 4 by 4 inches of space in the laboratory or other area with instruments requiring a voltage less than that at the available outlets. The instrument to be regulated is merely plugged into the convenient outlet in the rear of the small variable transformer and the Controller is connected to a nearby power line. A graduated scale on the face permits duplication of any setting. **Fisher Scientific Co., 717 Forbes St., Pittsburgh 19, Pa.**

For more details circle #80 on mailing card

(Continued on page 220)

Snow Thrower Has Special Raker Bar

The new Champion Snow Thrower has a special raker bar that quickly cuts up heavily packed or deeply piled snow. It is especially designed for use around hospitals, schools and other institutions. The raker bar consists of six flat steel teeth mounted on the Champion whirling fan. The bar is so arranged that it cuts the packed snow into small pieces that can be easily thrown by the fan.

The new rotary type machine is self-propelled and powered by a 2½ h.p. gas engine. It is designed to clear a path 20 inches wide through any depth or type of snow. Snow is thrown over a large area and the throwing angle is adjustable. Other features include open construction to prevent clogging or stalling; working parts protected by a wrap-around hood; adjustable handlebar; independent clutch for easy starting; two forward speeds for smooth operation, and 16 inch solid rubber wheels that grip firmly on all surfaces. **Jari Products, Inc., 2990 Pillsbury Ave., Minneapolis 8, Minn.**

For more details circle #81 on mailing card

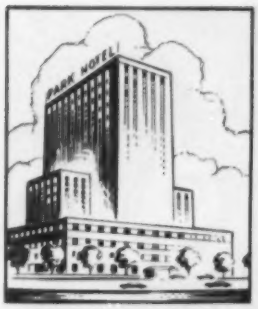
Automatic Coffee Maker Has Push-Button Operation

Uniformly good fresh coffee is ready at any time without waiting when made in the E-Z Way Model 4B Automatic Coffee Maker. Push-button operation is available for automatic filling of a ten cup serving decanter or for manual operation to fill a cup or partly fill a decanter.

Liquid coffee concentrate prepared from restaurant type soluble coffee or frozen type liquid concentrate is used in the dispenser to make fresh coffee available whenever needed, without waiting. Operation is adjustable for coffee strength and decanter sizes. Hot water is available from a third push-button for making tea, hot chocolate and for other purposes. The unit will serve from 40 to 400 cups of coffee per hour. It requires minimum space, is insulated, safe and easy to handle. **Steel Products Co., 40 Eighth Ave., S. W., Cedar Rapids, Ia.**



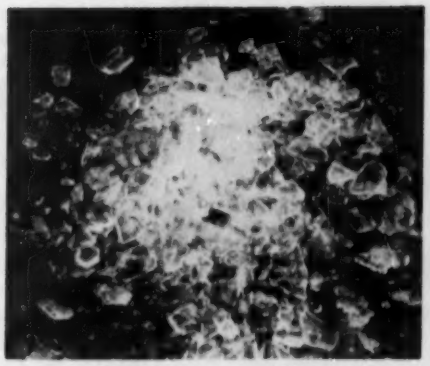
For more details circle #82 on mailing card



Institutions of All Sizes Find Shell-Ice Saves Money



Shell-Ice Being Blown into the Hold on a Fishing Vessel at Velasco, Texas



Shell-Ice Consists of Solid, Slightly Curved Pieces, and With Average Good Water Is Clear

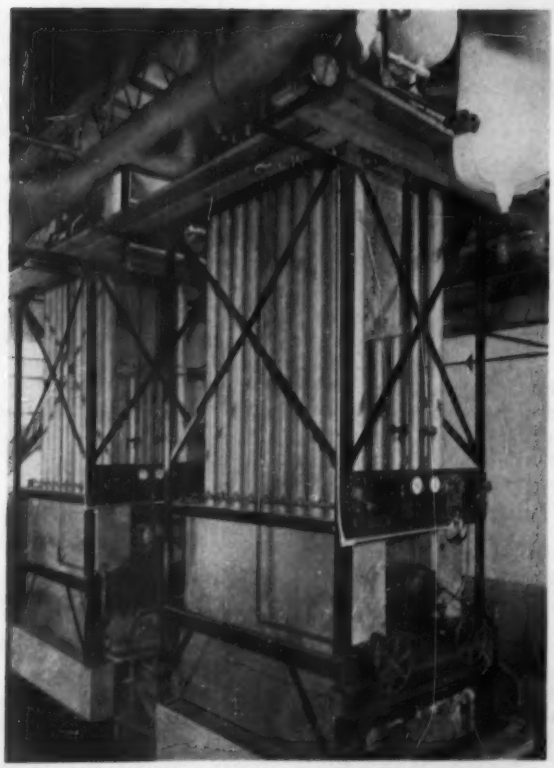
HARVEST NEW PROFITS with

FRICK

Shell-Ice*



Shell-Ice Can Be Scooped, Shoveled, Bagged or Conveyed.



Pair of 20-Ton Shell-Ice Makers in Operation

This new kind of ice is frozen automatically on stainless-steel tubes—no labor, no crushing, no snow, waste or special cleaning.

Shell-Ice is ideal for use in cooling drinking water and beverages, bottled milk, fish, poultry, fruits, vegetables, displays, trucks, etc., etc. Pieces are ⅛ to ½ inch thick, as desired: ¼-inch ice is harvested every 10 minutes.

Shell-Ice Makers can be connected to your existing refrigerating system, if preferred, since they operate on direct-expansion refrigerant. Built in 12 sizes, making ½ to 30 tons of ice per 24 hours. Small floor space required. Many already installed.

Get the full facts and figures: ask for Bulletin 54 today. *Trade Mark

DEPENDABLE REFRIGERATION SINCE 1882

FRICK CO.

WAYNESBORO, PENNA. U.S.A.

WHAT'S NEW

Multi-Controller for Paralysis Patients

The Tomac Multi-Controller provides an automatic touch control for buzzer



system and for any four electrical devices, giving freedom of action for paralysis patients. A slight touch on one small switch permits the dependent patient to control any five electrical devices, separately or all together. The appliances are selected by a simple touch code the patient learns in a day. Only slight movement is required for the patient to turn on his radio or television set, to signal for the nurse or to turn on a bed light. The patient can even use the telephone with the Multi-Controller.

The patient activates the appliance or appliances wanted by the number of touches and timing given the Multi-Controller switch. A different number of touches turns off each appliance. The Multi-Controller is a simple device requiring no more care than a radio. It is plugged into the electrical devices desired and is ready to operate. It consists of four outlets, built-in buzzer and micro-switch with clamp. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #83 on mailing card

Heavy-Duty Chair in Narrow Size

The new Model 556 Chair That Folds is a full-sized, heavy-duty chair in every respect except that it is 2¼ inches narrower in the seat width than the standard chair. This permits increased seating space and requires less storage space. The chair is durable and strong, has extra strength in the back-frame construction, and will stand hard use and abuse. It is modern in design with Rastetter steel



hinge and brace construction for ease of folding and extra strength. **Louis Rastetter & Sons Co., 1300 Wall St., Fort Wayne 1, Ind.**

For more details circle #84 on mailing card

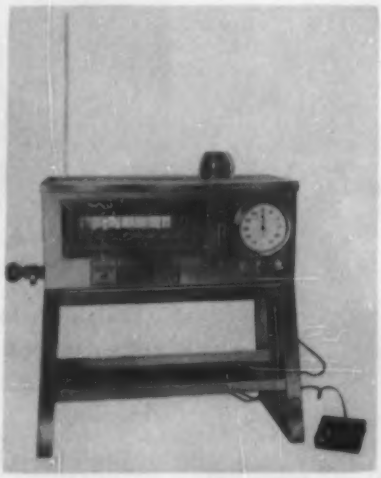
Chlorinated Cleaner Fulfills Three-Fold Purpose

A chlorinated detergent which cleans, deodorizes and sanitizes in one operation is available in Oakite Chlor-tergent. The new cleaner is readily soluble in cold or warm water. It destroys bacteria and odors on contact and brightens stainless steel as it cleans. The absence of suds makes Oakite Chlor-tergent particularly useful for in-place cleaning and sanitizing. **Oakite Products, Inc., 19 Rector St., New York 6.**

For more details circle #85 on mailing card

Clotting Timer Is Packaged

Chronothrombin is the name given to a new prothrombin clotting timer. The completely packaged apparatus consists of a constant temperature bath with timer, stirrer and lighting provisions for a simple and quick method of assay. It is coordinated to eliminate variables



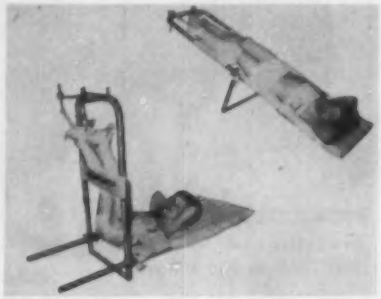
and to allow consistent reproduction of a given test. **Modern Laboratory Equipment Co., Inc., 1809 First Ave., New York 28.**

For more details circle #86 on mailing card

Traction Frame Reduces Circulatory Complications

A new infant traction frame is available which can be used either for suspension traction or Bryant's traction in treating fracture of the femur in children of various age levels. It eliminates factors causing Eschemia of the leg, including hydrostatic pressure, artery compression and impeded circulation due to too tight bandaging.

For children aged two to four years, the frame is used for suspension traction with a supporting band placed behind the upper calf to keep knees in slight flexion. For older children, to ten years, the frame is easily converted to extension traction. Use of the frame permits substituting skeletal traction for skin traction in the older group. The frame can be conveniently transported for continued treatment at home when it is



deemed necessary, and it is readily disassembled for storage in small space. **Orthopedic Frame Co., 420 Alcott, Kalamazoo, Mich.**

For more details circle #87 on mailing card

Acoustical Suspension With Flexibility

The Accesso Acoustical Suspension System provides immediate accessibility and flexibility. Lights and other ceiling fixtures can be moved in acoustical tile ceilings one module or a dozen in a matter of minutes with the new system. Air conditioning, telephone lines, electrical ballasts and other utilities are instantly accessible and may be repaired or moved without damage to the tile.

The fully concealed system of steel channels and hangers may be installed with minimum labor. Pairs of intergripping angles are clipped to standard supports and slipped into kerfs on two sides of each acoustical tile. An excellent finished job is presented with any size or make of tile. No metal is exposed and the ceiling presents a monolithic effect of unframed tiles, perfectly aligned.

The design is such that each one foot square or one by two foot tile can be lifted up and rested on the top side of the ceiling. A large space can thus be cleared in a minute, for access to utility lines, fixtures and duct work above. Maintenance men have instant access through any single tile or a number of tiles any place in the ceiling. A damaged tile may be replaced individually



without disturbing any other. Both original and maintenance costs are described as low. **Accesso System, Inc., 4615 Eighth Ave. N. W., Seattle 7, Wash.**

For more details circle #88 on mailing card

(Continued on page 222)



THE BRUSH OF CHOICE

ANCHOR *All-Nylon* SURGEON'S BRUSH

Tough...Guaranteed to withstand more than 400 autoclavings

Gentle...Tufts are soft but firm...specially tapered for better scrub-up efficacy with more comfort

Anchor Brushes weigh only 1½ oz. . . . grooved handles for firmer gripping . . . crimped bristles for better soap retention . . . designed for efficient use in Anchor's modern brush dispensers.

Anchor Brushes save money for you because of their unusual durability and outstanding performance. They are the most economical on the market today.

Order by the dozen or gross from your hospital supply firm . . . today!

Other outstanding Anchor Products...
the new All-Nylon Emesis Basins
All-Nylon Drinking Tumblers
Stainless Steel Surgeon's Brush Dispensers



Sold Only Through Selected Hospital Supply Firms

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When you buy Walrus Casework you have a selection of several hundred Walrus stock and special units all the result of careful research by our engineering department and backed by a firm with a history of more than fifty years successful manufacturing experience.



Walrus is the quality leader in Casework of stainless steel, enameled steel, and wood.



WALRUS
MANUFACTURING COMPANY
DECATUR ILLINOIS

WHAT'S NEW

Improved Ice Cart of All Stainless Steel

Stainless steel is used throughout in the improved Model 75 Ice Cart. It is easy to keep clean and resists deterioration due to moisture. Heavy duty three inch insulation keeps melting of ice at a minimum when the cart is used for service to patient rooms or in floor kitchens. An easily reached, hand operated drain in the bottom of the cart facilitates emptying and cleaning. The stainless steel lid lifts off for use and the compact cart holds 75 pounds of cubed, flaked or cracked ice. It is easily maneuvered on one pivoted and two stationary hard-rubber wheels. A rubber guard at the bottom protects walls and doors. **Gennett & Sons, Inc., Richmond, Ind.**

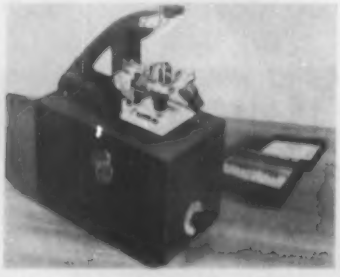


For more details circle #89 on mailing card

Micro-Projector Permits Group Viewing

The Victor Magnascope V200 is designed to enlarge microscopic specimens up to thousands of diameters. With the unit specimens can be projected on a screen for classroom or other viewing by large groups, or directly down on a table or desk top for small groups and for sketching purposes. Image size for screen projection is controlled by the distance of the Magnascope from the screen.

The compact unit weighs only eight pounds and features a variable light focus. It is equipped with two microscope objective lenses mounted on an indexed turret for fast, positive positioning over the specimen stage. Lenses are interchangeable with any standard microscope lens. The specimen stage is always level, whether projecting on screen or table top. The motor is blower cooled for sustained operation and a heat filter protects live specimens. It is of all metal construction, finished in sage green scratch resistant enamel, and comes complete with carrying case. **Victor Animatograph Corp., Davenport, Iowa.**



For more details circle #90 on mailing card

Levin Mobil-Bath Saves Space and Cost

A patient's room with toilet and lavatory can be supplied in ordinary room space with the new Levin Mobil-Bath. It provides all sanitary facilities in one mobile unit and is readily installed in either old or new buildings by connecting to the existing plumbing system. It rolls easily on concealed large diameter ball bearing casters. It can be used at the bedside or pushed into a corner behind a screen or folding door for use by ambulatory patients.

The Mobil-Bath has an electrically-flushed toilet which can be placed on the bed and used like a bed pan. The removable seat may be positioned for correct use on either side of the bed, or for use as a conventional toilet. On the other side is a lavatory with hot and cold running water. The complete unit revolves, independent of the base, for easy access to the toilet and to the lavatory.



The control cabinet, finished in green enamel, encloses all plumbing and the hose covering is of sanitary, washable plastic. The unit is easily raised or lowered by a control lever. It actuates the electric hydraulic elevating system which is silent and safe, having no motors or moving parts. A spray attachment is push-button operated for the convenience of the nurse in rinsing utensils. The lavatory is equipped with adjustable mirror and fluorescent light, chrome-plated holders for drinking glasses, chrome-plated soap dishes and electrical outlet. **Washington Technological Associates, Inc., 3000 Connecticut Ave., Washington 8, D.C.**

For more details circle #91 on mailing card

(Continued on page 224)

Wall Bracket Light in Modern Design

Modern lines are used in the new 43-40 McPhilben Wall Bracket light. It is constructed and designed for attractive appearance and long life. It is made of die-cast, satin anodized aluminum, threaded globe with gasket, and porcelain pre-wired lampholder. The new light is vapor-tight and dust-tight for efficient performance and minimum maintenance. It is available in styles for wall or ceiling installation in hospitals, schools and other institutions. **McPhilben Mfg. Co., Inc., 1329 Willoughby Ave., Brooklyn 37, N. Y.**



For more details circle #92 on mailing card

Wall Bracket Suspends Water Cooler

Ample clearance for floor cleaning equipment can be provided under water coolers with the new Cordleyrac Wall Bracket. Made of heavy gauge steel, the rack is designed to hold Cordley water coolers off the floor at any desired height, thus improving sanitation. **Cordley & Hayes, 443 Fourth Ave., New York 16.**

For more details circle #93 on mailing card

Redesigned Potato Peeler in Portable Table Model

Several new features are offered in the redesigned Peelmaster potato peeler. Casting thickness has been reduced to lighten weight and reduce costs. The interior is constructed to diversify the tumbling of potatoes and other vegetables on the abrasive peeling disc for smoother and faster results. The new luster two-tone exterior finish is easily wiped clean and all metal used is rust and corrosion resistant. The redesigned machine is available in table and floor models. **Service Appliance Co., Inc., P. O. Box 46, Norwalk, Conn.**



For more details circle #94 on mailing card

THE KAHLER HOTEL

Rochester, Minn.

designs for beauty

specifies "CHF" BRONZE



Kahler Hotel
Coffee Shop

New "CHF" Stools and Tables offer wider range of colors!

Like The Kahler Hotel shown above, your installation too, can be style-right and color-right when you choose Chicago Hardware Foundry Stools and Tables. Only at "CHF" will you find solid bronze . . . chrome . . . anodized aluminum . . . porcelain enamel in 11 colors . . . upholstery in so many choices. *Plus* newest designs . . . *plus* cast, one-piece construction for a lifetime of dependable service.

Top Award Winners in N.F.S. Contest!

Year after year, "CHF" Stools and Tables predominate in the country's winning installations in the National Food Service Contest.

Write for Color Catalog!

Shows complete line of stools and tables in color, plus many outstanding installation pictures.



Distributors in Principal Cities

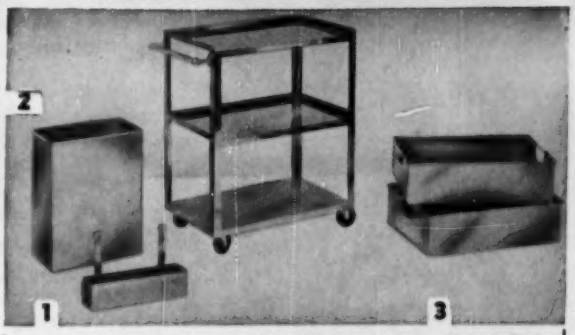
THE CHICAGO HARDWARE FOUNDRY CO.

"Dependable Since 1897"

41125 Commonwealth Avenue
NORTH CHICAGO, ILLINOIS



"Our new Bloomfield truck paid for itself in 3 months!"





Model No. 56 (above)

CUT OVERHEAD COSTS with STAINLESS STEEL ALL-PURPOSE TRUCKS by BLOOMFIELD

All-purpose trucks by Bloomfield are designed to serve efficiently and quietly in every part of today's modern hospital. Ideal as: *a kitchen truck, *surgical instrument cart, *medicine cart, *hospitality cart, *maid's truck *for transporting diathermy equipment, *for virtually every hospital moving job. *Write for information on specially designed trucks to meet other needs.*

MODEL NO. 56 LOW-COST TRUCKS

Model No. 56 (photo above) is a low-cost, sturdily made truck that will give years of useful service. Made of mirror-finished Enduro stainless steel, it can be kept perfectly clean with just minimum care. Available with or without stainless steel accessories as shown. Dimensions 27" long (including handle) x 31" high & 15½" deep. Price—$29.95.

MODEL NO. 36 HEAVY-DUTY TRUCK

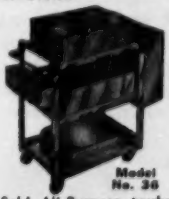
Model No. 36 is a ruggedly built truck, larger than No. 56 above, and is designed for durability and performance. Easily carries 350 lbs. Made of finest quality, heavy-gauge stainless steel, beautifully mirror-polished for complete cleanliness. Mounted on soft rubber-tired, ball bearing casters. Soundproof. Available with or without accessories. Dimensions: 30" long (including handle) x 31" high x 16½" deep. Price, $36.95.

ACCESSORIES FOR NO. 36 TRUCK

1. No. 236 Bin—Same as above.
2. No. 136 Bin—Same as above.
3. No. 37—Carrier—Smoothly finished stainless steel, with extra reinforcement, and rolled handles. Larger than No. 57 above. Price—$12.50.

LOW-COST ACCESSORIES FOR NO. 56 TRUCKS

1. No. 236 Bin—For silverware, condiments, medicines, other small items. Easily removable. Price—$6.49.
2. No. 136 Bin—For food scraps soiled or clean linens. Quickly cleaned. Removable. Price—$12.95.
3. No. 57 Carriers—For carrying foods, candles, bottles, dirty dishes, etc. Leakproof, sanitary. Smooth rolled handles. Price—$10.50.



Model No. 36

Bloomfield All-Purpose trucks can also be supplied in extra heavy gauge galvanized steel for use where stainless steel is unnecessary.
Model No. 34 (same dimensions as No. 36). Price—$22.95.
Galvanized steel accessories similarly low priced.

SEE YOUR JOBBER

Please send me complete details on Bloomfield All-Purpose trucks. Also send my copy of the new Bloomfield catalog of more than 200 important hospital items.

NAME.....
POSITION.....
HOSPITAL.....
ADDRESS.....
CITY.....ZONE.....STATE.....

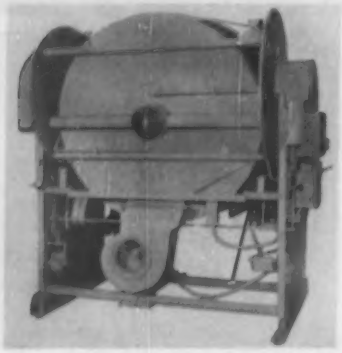
BLOOMFIELD

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CHICAGO 32, ILLINOIS
NEW YORK • LOS ANGELES

WHAT'S NEW

Conditioning Tumbler Includes Pre-Drying

The new 48 inch Purkett Conditioning Tumbler incorporates pre-drying in the



same machine. It is claimed that the machine removes an additional gallon of water in five minutes of tumbling time. The machine has many improvements in the cylinder drive and unloading mechanism for greater ease and efficiency of operation.

A new 72 inch pre-drying tumbler is also announced by the manufacturer. Improvements include an enlarged steam coil and a larger blower fan for more efficient operation. **Purkett Mfg. Co., Joplin, Mo.**

For more details circle #95 on mailing card

Food Mixer Has Automatic Timer

A completely automatic timer on the new Model 1222 Portable 22 quart Univex Food Mixer allows speed changes without stopping. The low cost, powerful unit features an elevating and swing bowl action that permits mixing at adjustable depth; planetary mixing action; ease of loading and unloading, and a power take-off at the front of the machine that allows the use of standard attachments such as meat choppers, vegetable slicers, knife and tool sharpeners



and other accessories, with the Univex Special Adapter. **Universal Industries, Inc., 360 Mystic Ave., Somerville 45, Mass.**

For more details circle #96 on mailing card

Freedom of Movement in Surgeon's Gown

A new surgeon's gown with Dynaflex Action is now available. A set-in panel under the arm permits complete freedom of movement and comfort in action. Under-arm binding and bunching are eliminated and the gown does not "ride up." The Panel Seam design does away with direct under arm seams providing lessening of strain and complete ease in action. **H. W. Baker Linen Co., 315 Church St., New York 13.**

For more details circle #97 on mailing card

Bone Grafting Material from Healthy Calves

A compatible bone graft obtained from healthy calves and packaged under sterile conditions is offered for orthopedic use as the result of ten years of research. The grafts are processed to eliminate heterogeneous bone reactions in humans. The process also makes the grafts conducive to early union and encourages rapid union in old ununited fractures, according to Dr. E. J. Tucker, orthopedist of Houston, Texas. The bone can be stored in an ordinary refrigerator at 40 degrees F. with other biologicals. The cost to the patient is said to be comparable to that of a pint of blood and there is no danger of transmission of obscure infections as is possible in human bank bone, such as latent syphilis and viral hepatitis.



The grafts are available in sizes approximately 1½ by 4 inches and 1½ by 6 inches. Availability of the graft material in the bone bank saves additional surgery. Ground bone for use in bone defects and bone cavities where early osteogenesis is desired is also available in one ounce vials. **National Bone and Tissue Laboratories Inc., P. O. Box 529, Houston 1, Texas.**

For more details circle #98 on mailing card

Housekeeping Cart Is Light and Strong

Model S-120 Bucksco Housekeeping Cart is constructed of Temper-luminum, an aircraft aluminum alloy which is strong and rigid and yet light in weight. The aircraft riveted construction gives durability and the unit is completely bumpered to prevent marring walls and doorways.

The cart has compartments for carrying all housekeeping equipment, includ-



ing buckets, mops, cleansers, cleaners and other supplies. It rolls easily at a touch on five inch ball bearing neoprene-tired casters, two rigid and two swivel. The cart is bright and attractive in appearance, resists dents and is easy to clean. It is 49 inches high, 22 inches wide and 59 inches long. **Bucks County Enterprises Inc., Quakertown, Pa.**

For more details circle #99 on mailing card

Toasting Appliance, for Buns and Muffins

The Savory RotoBun is a counter toasting appliance designed especially for toasting hamburger buns, English Muffins and similar foods. It is 11½ inches wide, 22 inches deep and stands 15½ inches high. It has a capacity of four half buns per minute and operates on standard current, drawing minimum power. It can be plugged into existing electric currents and provides supplementary service to the Savory Conveyor-Type Toasters, or service where the demand is small, as in floor kitchens or other areas serving a limited number of meals.

Constructed of stainless steel, it has a horizontal conveyor moving from front to back under the single heating element. Toasted buns or muffins drop off the



conveyor on to a chute which delivers them to the front of the machine. Heat is controlled by an infinite control switch and a lever device. **Savory Equipment, Inc., 120 Pacific Ave., Newark 5, N.J.**

For more details circle #100 on mailing card

(Continued on page 226)

Only the patented

NipGard
TRADEMARK

DISPOSABLE NIPPLE COVERS . . .
Offer this Simplicity and Security



Illustrations show speed and security afforded by NipGard* protection to nursing bottles:

1. Identification and formula data is written on cover.
2. Quickly applied to nipple . . . saves nurse's time. Covers nipple & bottleneck!
3. Exclusive patented tab construction fastens securely to nipple.

Does not jar off . . . no breakage. Used extensively by hospitals requiring terminal sterilization. Professional samples on request. Order through your hospital supply dealer.

Use No. 2 NipGard for narrow neck bottle . . . use No. H-50 NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.

*PATENTED

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110 N. Markley St. (Dept. T)
Greenville, South Carolina



DIRTY FLOORS
CLEAN THOSE
Silently
WITH WHITE SILENT
MOPPING EQUIPMENT



SILENT OVAL BUCKET
White Silent Cleaning Equipment is especially made for use in hospitals and institutions where quietness is essential. The Silent Oval Bucket illustrated is fully insulated against noise by use of rubber at all points of metal to metal contacts.



SILENT ROL'OVL
The famous White Rol'Ovl Mop Wringer is insulated throughout against noise in operation. Equipped with rubber rollers.



SILENT MOPMASTER
The most efficient Double Mopping Outfit made with the added features of silent operation. Two Silent Oval Buckets — one for cleaning solution and one for rinse water and the "Can't Splash" Squeezer combined with a sturdy rubber protected steel truck that moves quietly and easily.

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WHITE

A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

How Kenwood HOSPITAL Blankets direct from the Mill - save you money!

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For swatches, prices and full information write to:

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CONTRACT DEPT.
Empire State Bldg.
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WHAT'S NEW

Safety Humidifier Requires Infrequent Filling

The new bubbler-type NCG humidifier has a plastic jar which assures safety since it has high resistance to breakage.



It has been tested to withstand pressures up to 100 pounds per square inch. The jar cap incorporates an improved poppet-type relief valve which gives an audible alarm if oxygen flow to the patient is cut off by kinked hose, clogged outlets or other obstructions. The humidifier operates approximately 24 hours without refilling. A porous metal insert provides high humidity by breaking up oxygen flow into tiny streams, permitting increased moisture pick-up. The humidifier is pictured with the most recent NCG model piped oxygen outlet and adapter. **National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11.**

For more details circle #101 on mailing card

Electric Counter Line Has Satin Chrome Finish

Sturdy construction, faster heating and functional design are some of the features of the new custom-design Griswold electric counter line. Units in the line include an electric fry kettle, food warmer and two sizes of griddles. All items are designed to fit in any desired arrangement or numbers for counter installation. Satin Chrome finish and red operating knobs make it attractive in appearance and easy to keep clean.

The units can be installed anywhere as they will fit a narrow, 17 inch wide counter. A recess in the back of each unit for conduit or cord and plug permits flush-to-wall mounting. The matched design gives custom built appearance and each item has adjustable levelling feet. **Griswold Mfg. Co., 12th & Raspberry, Erie, Pa.**

For more details circle #102 on mailing card

Wall-Mounted Conductometer for Operating Room

Designed to safeguard against static spark explosions in operating rooms, the new Conductometer Model UL 90-500A has Underwriters Laboratories approval, according to the manufacturer. Flush mounted in the wall five feet above the floor just inside the entrance to the operating room, the Conductometer has an elbow switch which permits personnel testing under aseptic conditions. All persons entering the operating room can check their electrical resistance before approaching the operating table. The indicator scale is in color and easily read. The electrically operated testing instrument is constructed to meet all requirements of NFPA Booklet No. 56, May 1954. **Conductive Hospital Accessories Corp., 82 W. Dedham St., Boston 18, Mass.**

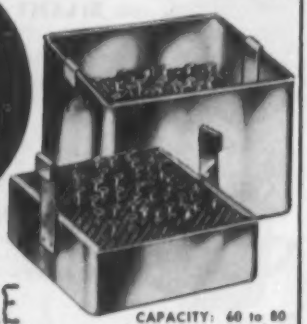


For more details circle #103 on mailing card

(Continued on page 228)

Protect HOSPITAL PERSONNEL AGAINST Infectious HEPATITIS

MADE OF STAINLESS STEEL



CAPACITY: 60 to 80 Needles up to 2" long

Hasco SOILED NEEDLE CONTAINER

- Protects Nursing and C.S.R. Personnel against infection.
- Protects Needle Points after use.
- Helps prevent Needles from clogging.
- Practical, effective method of collecting Needles and returning them to C.S.R.
- Provides convenient method of handling Needles.

All Stainless Steel. 1 piece outside container.



Cut-away View showing Needle inserted between double layer meshing.

No. MNC 26 — Hasco SOILED NEEDLE CONTAINER $13.50 Each

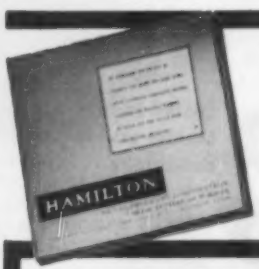
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*Cerebral Palsy Hospital
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Machine Packed in Osnaburg Bags

DDs COST LESS ON THE JOB THAN ANY OTHER

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36 DOZ. PER BAG

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You will have to use "Dexter Diapers" to believe them. They go on and off baby in a jiffy—without folding, save half the changing time in your nursery. In your laundry they are easier to count, wash, dry, wrap, need no folding, take up less room, last longer, cut your laundry costs right in half. They are nationally advertised in 26 publications as an institution diaper. Ask your Diaper Service Company or write direct to Dexter Diaper Factory for sample and free booklet with facts about diapering written by a famous physician.

DEXTER DIAPER FACTORY, HOUSTON 8, TEXAS

What do you know about buying casters?



Here are all the facts

All casters are *not* the same. They differ in quality of construction and material. They differ in the way they do their job. And they differ even more in durability.

Be sure... buy Bassick

The safest way to buy casters is to specify Bassick's — made by the world's leading manufacturer of floor protection devices. We've made it easy for you with the catalog above. It's packed with specific facts and figures as well as clear illustrations of the complete Bassick line of institutional casters. It's in the Hospital Purchasing File, of course, but we'll be glad to send you a copy on receipt of the coupon.

For heavy-duty jobs

Another Bassick catalog (right) you'll find useful describes our casters with rubber-tired disc wheels — built for medium and heavy duty on trucks and similar equipment. A copy is waiting for you. The Bassick Company, Bridgeport 2, Conn. *In Canada:* Belleville, Ont.





Bassick
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The Bassick Company Bridgeport 2, Conn.

Please send me copy of catalog(s) checked:

☐ Bassick Institutional Casters Catalog HPF-54
☐ Bassick Rubber-Tired Disc Wheel Casters Catalog 4R-55

Name _____ Title _____

Address _____

City _____

State _____

WHAT'S NEW

Pharmaceuticals

Solu-Cortef

Solu-Cortef is a sterile powder form of hydrocortisone, highly soluble in water, for intravenous injection. It is effective in obtaining rapid high blood levels of hydrocortisone. It is described as suitable for emergency therapy in cases of acute adrenal cortical insufficiency, various states of shock, post antibiotic treatment in overwhelming infection, severe allergic reactions and status asthmaticus. The solution is stable at room temperature and below for three to five days if protected from light. Solu-Cortef is available in 10 cc vials. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #104 on mailing card

Lutrexin Tablets

Lutrexin is a new water soluble, nonsteroid, uterine relaxing factor. The new ovarian hormone is said to be entirely unlike estrogen or progesterone. It is indicated in the management of premature labor and threatened and habitual abortion. Lutrexin specifically relaxes the contracted uterine muscle by direct action thereon or by blocking pituitary stimulation, according to reports. It is supplied in bottles of 25 tablets. **Hynson, Westcott & Dunning, Inc., Charles & Case Sts., Baltimore 1, Md.**

For more details circle #105 on mailing card

Nembu-Serpin Tablets

Filmtab (R) Nembu-Serpin Tablets are indicated as a sedative-tranquilizing-antihypertensive agent for mild anxiety states and mild essential hypertension. A combination of Nembutal(R) and Reserpine, the synergistic effect produces smooth, gentle, prolonged sedation. It is also indicated for its sedative and tranquilizing effect in the treatment of mild essential hypertension. It is supplied in bottles of 100 and 500 Filmtabs. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #106 on mailing card

Equanil

Equanil is a new drug designed to bring quick and safe relief to patients suffering from tenseness and anxiety neuroses. It acts as a central nervous system depressant, lessening tension and assuring restful sleep and generalized muscle relaxation. It is a derivative of propanediol and has a selective interneuronal blocking action. Clinical investigation has indicated that the drug is non-habit forming. **Wyeth Laboratories, Inc., 1401 Walnut St., Philadelphia 2, Pa.**

For more details circle #107 on mailing card

Cortrophin-Zinc

Cortrophin-Zinc, a new advance in ACTH therapy, provides corticotropin with zinc hydroxide for repository action. Because of modification of ACTH by zinc hydroxide, each cc provides therapeutic ACTH activity for periods of from one to three days. It requires no heating prior to administration and is a fine aqueous suspension which flows freely through a 24-26 gauge needle. It provides the complete physiologic action of ACTH, enhanced, prolonged and with convenience of administration. It is indicated in the treatment of shock, rheumatic afflictions, allergic reactions, skin and eye diseases and other stressful conditions amenable to ACTH therapy. **Organon Inc., Orange, N. J.**

For more details circle #108 on mailing card

Ambar Tablets and Extentabs

Yellow compressed Ambar tablets and yellow, coated Ambar Extentabs contain a combination of methamphetamine with phenobarbital. Ambar is indicated for the relief of symptoms in the tension-anxiety states and as an appetite depressant in controlled weight reduction. The equivalent of three Ambar tablets is contained in each Ambar Extentab, the relief of active ingredients being so controlled that each Extentab provides therapeutic effects of the intensity of one Ambar tablet uniformly sustained for ten or twelve hours. Both products are supplied in bottles of 100 and 500. **A. H. Robins Co., Inc., Richmond 20, Va.**

For more details circle #109 on mailing card



For "Modified Diets" or Regular Feeding

YOU can prepare your patients' meals with more efficiency and less cost. That important expense may be cut considerably without impairing calorie-content. The preparation and serving of foods may be handled quicker, more thoroughly and with less lost motion by using DON—

EQUIPMENT • FURNISHINGS • SUPPLIES

Even a general or "special diet" kitchen may be obsolete or antiquated and may need mo-lernizing. Dish washers, food mixers, apple parers, potato peelers, food carts and other equipment will save time. These and others of the 50,000 items you may need are sold by DON. Every item sold on a guarantee of satisfaction or money back.

Write Dept. 14 for a DON salesman to call —or in Chicago phone CAlumet 5-1300.

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A NEW BINDER for "THE MODERN HOSPITAL"

Protect your copies of "The Modern Hospital" with these modern Vulcan Binders! One binder will hold 6 copies, two binders will hold a complete year's issues, 12 issues in all. Binders are made of heavy-weight board and are covered with dark blue, drill quality, imitation leather stamped in gold foil. Backbone panel gives space for labeling volume and year. Individual wires hold each issue securely, make insertion easy.

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WHAT'S NEW

Product Literature

• **"Within These Doors"** is the title of a new 25 minute black and white film, with sound narration, produced especially for hospitals by The American Laundry Machinery Co., Cincinnati 12, Ohio. Approved by the Film Review Board of the American Hospital Association, the film dramatizes the vital service hospitals perform in their communities. Authentic scenes were taken in various hospitals showing many departments, from out patient to surgery, as well as laundry departments in operation in different types and sizes of hospitals. The importance of the hospital laundry to the proper functioning of each department is shown as are the many factors involved in planning a new or modernized laundry, from the initial inception to the final installation of equipment. The film is suitable for showing to hospital personnel as well as to the public. It should prove effective in increasing public appreciation of the services performed by the hospital and as an aid in raising funds for new hospital construction or improvement of facilities.

For more details circle #110 on mailing card

• Information on a complete assembly of equipment grouped for planning a modern nursery is offered in the new **"Nursery Equipment"** catalog issued by A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo. The equipment covered is described as being "designed for modern standards of care for the newborn infant" and covers bassinets, hampers, nurses' station furniture, examining tables, waste receptacles, utility tables, storage units, incubators and other equipment. A suggested layout for the nursery is included.

For more details circle #111 on mailing card

• The use of cold in medicine and surgery is discussed in two leaflets published by Therm-O-Rite Products Corp., 1748 Main St., Buffalo 8, N.Y. How the **Therm-O-Rite Hypo-Hyper-Thermia Unit** is used in medicine and surgery, what it is, and applicators available is an interesting story. Specifications, technics and digests of actual cases are included in the leaflets.

For more details circle #112 on mailing card

• The rules to follow when laying kiln-dried hardwood flooring are contained in **"Please Don't,"** a leaflet brought out by the Maple Flooring Manufacturers Association, 35 E. Wacker Dr., Chicago 1. The first part of the leaflet contains suggestions for the installation and care of Northern hardwood flooring. A list of simple precautions to take in handling hardwood flooring at the job site is found in the second part.

For more details circle #113 on mailing card

• **"Trion Electronic Air Cleaners at Work in the Hospital"** is the subject of Application Study No. 114 released by Trion, Inc., McKees Rocks, Pa. The application, requirements and benefits of the use of air cleaners in hospitals are discussed with the story of an actual hospital installation and how it operates.

For more details circle #114 on mailing card

• How **"Instant Automatic Floodlighting"** can serve your hospital in case of power failure or other emergency is the subject of a folder released by U-C Lite Mfg. Co., 1050 W. Hubbard St., Chicago 22. Big Beam Automatic Lights are described and illustrated, and line sketches show how Big Beam installations can serve effectively in operating rooms, corridors, stair wells and many other areas in the hospital. Various models of Big Beam Automatic Lights are shown with data on their operation and power.

For more details circle #115 on mailing card

• Accurate information on **flooring problems** can be obtained through a plan introduced by The Monroe Company, Inc., 10703 Quebec, Cleveland 6, Ohio. This new plan is based on a comprehensive survey to be used by the maintenance engineer in checking his floors. Monroe flooring experts study the report and make definite recommendations based on experience of thirty years of handling floor problems.

For more details circle #116 on mailing card

(Continued on page 230)

Developed by
EICHENLAUBS



Intermediate Height
HOSPITAL BED

The economical answer to the question of "HIGH-LOW" Beds

Write for descriptive **BULLETIN IH**

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E-10

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CASH'S WOVEN NAMES

prevent loss or mixups of linens, uniforms and other personal belongings. Your name actually woven into fine white cambric ribbon. Easily attached — sew on or use CASH'S NO-SO boil-proof CEMENT.

6 Doz. $2.75, 12 Doz. $3.75, 24 Doz. $5.75. At notion counters everywhere. Write for samples.

Cash's
WOVEN NAMES
SOUTH NORWALK 12, CONN.

WHAT'S NEW

• **Procedure Manual 1, "Safety Sides—A New Safety Measure,"** is available from Hill-Rom Company, Inc., Batesville, Ind. Prepared by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom, the 8 page booklet is prepared in true manual style with procedures described and illustrated by photographs. Line drawings picture many of the parts and steps discussed.

For more details circle #117 on mailing card

• An attractively laid out booklet tells the story, in text and sketches, of the **Self Closing Ropeless Hamper Bag.** Operating safely without ropes or grommets, the bag efficiently handles laundry with minimum effort on the part of personnel. Information on its use is interestingly presented in the booklet published by the Self Closing Ropeless Bag Co., 548 Asylum St., Hartford, Conn.

For more details circle #118 on mailing card

• **The complete line of "Chemical Porcelain Laboratory Sinks"** manufactured by The U. S. Stoneware Co., 60 E. 42nd St., New York 17, is described and illustrated in **Bulletin L-8.** The 20 page bulletin is printed in three colors and gives data on how these sinks are made, including dimensional drawings and charts for sinks, outlets, drains and traps.

For more details circle #119 on mailing card

• The story of Fleetlite Windows is told in a folder headed, **"How are Your Windows?"** Released by Fleet of America, Inc., 515 New Walden Ave., Buffalo 25, N. Y., the leaflet is fully illustrated and describes the Fleetlite double windows and Fleetlite balanced insulating sash.

For more details circle #120 on mailing card

• **"The Role of Elastic Hosiery in Common Leg Disorders"** is the title of a booklet recently published by Becton, Dickinson & Co., Rutherford, N. J. The booklet describes the built-in gradient of pressure for effective support to the veins of the leg; the elastic heel that assures proper and positive pressure and the full-foot which anchors the hose in place and applies support to the lowest collecting vein system in the foot.

For more details circle #121 on mailing card

• **"Cement Enamel, a Vitreous Surfacing for New and Existing Walls"** is the title of a four page folder released by Cement Enamel Development, Inc., 18636 Fitzpatrick Ave., Detroit 28, Mich. It tells the story of the washable, sanitary, permanent glazed walls which are produced by this new type of wall finish. Cement Enamel is a surface application of Portland cement combined with various chemicals and non-fading oxide colors, which hardens to produce the glazed surface. Application to new and old surfaces of all types is discussed in the folder which gives a list of installations.

For more details circle #122 on mailing card

• How the Vacuslot Cleaning System facilitates cleaning in hospitals, schools and other institutions is described in the **Spencer Bulletin No. 153-B.** Installation charts and specification data on this complete cleaning method are given in the bulletin which illustrates how dust mops up to 48 inches wide are cleaned by passing them over a vacuum slot flush with the floor. How erasers, hand dusters and other cleaning equipment are freed from dust and dirt which goes directly to the basement is discussed in the bulletin available from The Spencer Turbine Co., Hartford 6, Conn.

For more details circle #123 on mailing card

• **Shane Comfort-Tailored Hospital Apparel** for Operating Room, Patients and Auxiliary Personnel is described in a new hospital catalog issued by Shane Uniform Co., Inc., Evansville 7, Ind. Sketches and descriptive information on uniforms for the surgical team are given in the catalog.

For more details circle #124 on mailing card

• **Fedair Remote Type Heating and Cooling Units** are discussed in Bulletin HC-C2 offered by Fedders-Quigan Corp., Dept. HCR, Heating Div., Lalor and Hancock Sts., Trenton 7, N. J. Capacities and dimensional data on standard sizes for floor mounted and semi-recessed installations are given as are specifications, dimensions and other data.

For more details circle #125 on mailing card

• The Lowerator Division of American Machine & Foundry Co., 261 Madison Ave., New York 16, has issued a colorful new 24 page catalog. The complete **AMF Lowerator Dispenser line** is illustrated and described with specifications for each model. Keyed dimensional drawings and tables of sizes are given for easy selection of Lowerator Dispenser models for maximum efficiency and utility. Information is included on the planned system for automatic dispensing and storage of dishes, cups, saucers, bowls, trays, glasses, milk, juices and bread.

For more details circle #126 on mailing card

• A new 16 page catalog gives detailed information on the full line of **Bestwall Gypsum Wallboard Products** manufactured by Certain-teed Products Corp., 120 E. Lancaster Ave., Ardmore, Pa. Photographs and line drawings supplement product descriptions and uses of plain, wood-grain and insulating gypsum wallboard, gypsum sheathing, wallboard joint treatment, fire-rated gypsum wallboard and wallboard accessories.

For more details circle #127 on mailing card

• **"Favorite Apple Desserts"** is the subject of a recipe booklet released by the Processed Apples Institute, Inc., 30 E. 40th St., New York 16. The 36 page booklet is attractively laid out and gives quantity recipes for apple desserts served in famous eating places throughout the country.

For more details circle #128 on mailing card

• The new **Double Row Duplex Oxygen Manifold** developed by Ohio Chemical & Surgical Equipment Co., Madison 10, Wis., is discussed in a new illustrated folder available from that company. Features described in the folder include the automatic switch-over, space-saving design with greater oxygen capacity, audio-visual switch-over alarm system and a new pigtail connection.

For more details circle #129 on mailing card

• **Bulletin No. 136** on the **Barnstead Bottle Pump** describes how the unit pumps distilled water from tank or carboy while permitting only purified air to enter. Use of the special Ventgard filter removes and absorbs various impurities from the incoming air. The bulletin is available from Barnstead Still & Sterilizer Co., 219 Lanesville Terrace, Forest Hills, Boston 31, Mass.

For more details circle #130 on mailing card

• The new **Vinyl Asbestos Tile Color Chart** has recently been released by the Asphalt Tile Institute, 101 Park Ave., New York 17. Some 22 color combinations are listed in the chart which was designed to indicate what colors are included in each manufacturer's line

For more details circle #131 on mailing card

• **"Specifications for Using"** Satin Luminall and Luminall One Coat Light-Reflecting Paint for Interior Surfaces are offered in two folders prepared by National Chemical & Mfg. Co., 3617 S. May St., Chicago 9. Information on the products and their uses includes light reflection factors, coverage, cleanability, surface preparation and treatment and data on the various methods of application.

For more details circle #132 on mailing card

Suppliers' News

Ajusto Equipment Co., 2144 Madison Ave., Toledo, Ohio, manufacturer of office furniture, announces transfer of machinery, materials and equipment for the manufacture of Ajustrite chairs and stools from Garrett, Ind., to a new plant at **525 Conneaut Ave., Bowling Green, Ohio.** The new plant occupies over 19,000 square feet of floor space and provides a 20 per cent increase in production.

Sunroc Corporation, Glen Riddle, Pa., manufacturer of water coolers, drinking fountains, milk dispensers and other food handling equipment, announces acquisition of **P.O. Moore, Inc., 300 Fourth Ave., New York 10.** The present management, operations and field sales of P. O. Moore, Inc., manufacturers of TelKee control systems and equipment for filing and controlling keys to prevent theft and losses, will continue at Moore's North New Jersey plants. The new line is another step in the continuing program of diversification instituted recently by Sunroc.

PROD

In

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Physicians and Hospitals Su

65 Serological Pipettes
Corning Glass Works

66 Type H Hydroquacd
Powers Regulator Co.

67 Clip-Shaxpe
American Safety Razor Corp.

68 Universal Liquid Cleaner
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69 Glass Oven and Tableware
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71 Giant Washing Machine
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72 Handie-Talkie
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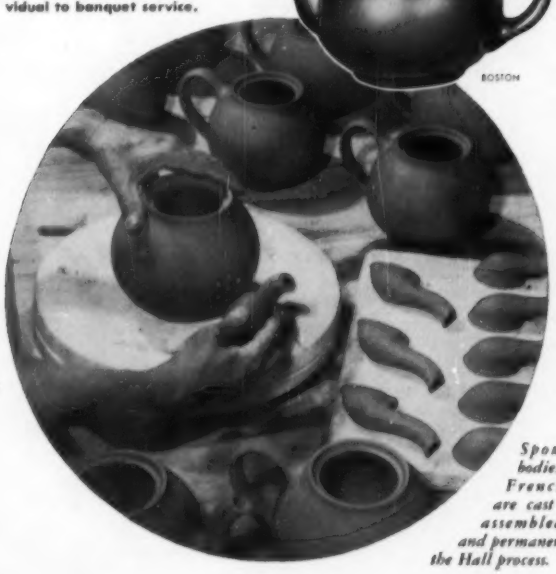








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Spouts and bodies of Hall French Teapot are cast separately, assembled by hand, and permanently joined by the Hall process.

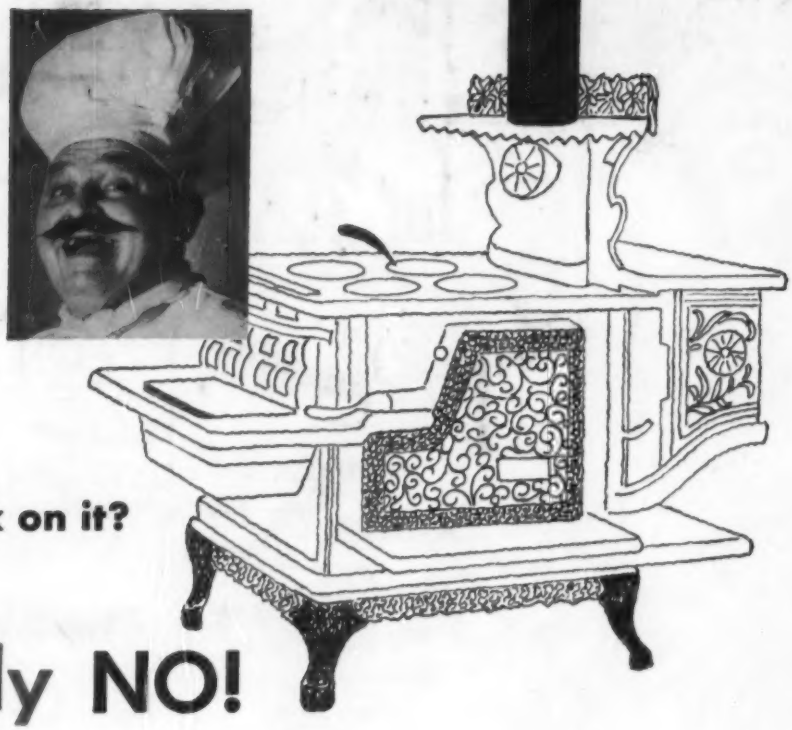
Guest satisfaction reaches a new high . . . china replacement a new low . . . when the service is Hall China. Hall teapots, made of heavy fireproof china by an exclusive process, are crazeproof, absorption-proof, and stainproof. Spouts, lips, and handles are extra strong . . . shapes are balanced for easy pouring, designed for easy cleaning.

Write for Bulletin SM-1 which lists and illustrates Hall casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, salads, and many other items available in 27 beautiful underglaze colors.

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The World's Largest Manufacturer of Fireproof Cooking China

HALL
Secret Process
FIREPROOF CHINA



would you cook on it?

Obviously NO!

... but you may, *WITHOUT REALIZING IT,*
be using products and methods *JUST AS OUT-DATED*
for running your business TODAY

BE MODERN . . . GO GUMPERT!

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